

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05377

Reg. Dist. No.

5407

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River #20</u>	c. LENGTH OF STAY IN 1b <u>54</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River #20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20 Seneca Gardens Road</u>		d. STREET ADDRESS <u>20 Seneca Gardens Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES HADDAWAY ADAMS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tugboat</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H. Adams</u>		14. MOTHER'S MAIDEN NAME <u>Chessie Fitchett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>217-14-5238</u>	17. INFORMANT <u>Anna J. Adams</u> Address <u>Same</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio Sclerosis Heart Dis.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal Ulcer - B.P.H.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		DATE SIGNED <u>5-22-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdziński</u>		24a. REC'D BY REGISTRAR <u>MAY 24 '60</u>	
ADDRESS <u>1407 Eastern Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10037

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH



THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON.
IT IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, AND A COPY OF IT IS TO BE SENT TO THE CLERK OF THE COURT IN THE COUNTY WHERE THE DECEASED PERSON RESIDED.
IT IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, AND A COPY OF IT IS TO BE SENT TO THE CLERK OF THE COURT IN THE COUNTY WHERE THE DECEASED PERSON RESIDED.

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED		SEPARATED		OTHER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF CLERK OF COURT		DATE		PLACE		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	

5408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7108 Queen Anne Road				d. STREET ADDRESS 7108 Queen Anne Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HARRY Middle R. Last ADAMS				4. DATE OF DEATH Month May Day 4 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 Jan. 28 1884	
9. AGE (In years last birthday) 76 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Detroit	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Adams				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-18-0623			
INFORMANT Maude M. Adams - 7108 Queen Anne Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach - 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastasis to liver - etc. - DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis -							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 6 - 19 53 to May 4 1960 that I last saw the deceased alive on April 30 - 19 60 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Chambers				ADDRESS (Street, city or town, state) 4108 Liberty Hts. - Bldg. - 7 - Hy. - 5460			
DATE SIGNED May 9 1960							
PHYSICIAN'S NAME (Type) EARL L. CHAMBERS				4108 - LIBERTY - HEIGHTS - AVE.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/1960		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost Ellsworth Armacost-4600 Liberty Hghts. Ave.				24a. REC'D BY REGISTRAR MAY 9 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1208

CERTIFICATE OF DEATH

1208

Baltimore

Baltimore

Baltimore

Villa Nova

Villa Nova

7108 Queen Anne Road

7108 Queen Anne Road

HARRY

HARRY

White

White

Civil Engineer

Baltimore

1208

Robert Adams

Unknown

No

214-10-0003 Maudie M. Adams - 7108 Queen Anne Rd.

Handwritten notes:
Maudie M. Adams
7108 Queen Anne Rd.
Baltimore, Md.
1208

Handwritten notes:
Maudie M. Adams
7108 Queen Anne Rd.
Baltimore, Md.
1208

Handwritten notes:
Maudie M. Adams
7108 Queen Anne Rd.
Baltimore, Md.
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Handwritten notes:
Maudie M. Adams
7108 Queen Anne Rd.
Baltimore, Md.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5409

CERTIFICATE OF DEATH

05379
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Nunnery Lane				d. STREET ADDRESS 22 Nunnery Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HIRAM Middle Last AIREY				4. DATE OF DEATH Month May Day 25 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1880		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales. Ret.		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Airey				14. MOTHER'S MAIDEN NAME Catherine Carle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		INFORMANT Address Allyne A. Airey 22 Nunnery Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Adeno-carcinoma of prostate DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardio vascular disease							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 8, 1958 , to May 25, 1960 , that I last saw the deceased alive on May 25, 1960 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue Baltimore 29, Maryland DATE SIGNED 5/27/60							
ACTUAL SIGNATURE George A. Knipp		M.D. George A. Knipp, M. D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 31 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG263 5-23-60 et

5410

CERTIFICATE OF DEATH

Reg. Dist. 05380

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Md.</i> c. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS <i>10707 Reisterstown Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>E.</i> Last <i>Albright</i>		4. DATE OF DEATH Month <i>May</i> Day <i>15</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 18, 1892</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>	
13. FATHER'S NAME <i>William Albright</i>		14. MOTHER'S MAIDEN NAME <i>Alberta Whittington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-12-2374</i>	
17. INFORMANT <i>Mrs. Gladys Miller</i>		Address <i>Hampstead, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic C.V.D.</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebellar cortical atrophy</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 4, 1948</i> , to <i>May 1960</i> , that I last saw the deceased alive on <i>2 May 1960</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. Williams</i>		ADDRESS (Street, city or town, state) <i>1632 Reisterstown Road</i>	
PHYSICIAN'S NAME (Type) <i>Charles H. Williams</i>		DATE SIGNED <i>Pikesville 8, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 19, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bosley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Eline & Sons</i>		ADDRESS <i>Reisterstown, Md.</i>	
24c. REC'D BY REGISTRAR DATE <i>MAY 17 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hearn</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1940

DATE OF DEATH

PLACE

DATE OF BIRTH

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DATE OF DEATH

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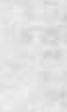
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DATE OF DEATH

PLACE OF DEATH

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DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5412

CERTIFICATE OF DEATH

05381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford A.A.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6yr3mth3dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Viola</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1904</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>56</u> Days <u>5</u> Hours <u>12</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Arthur Mason</u>		14. MOTHER'S MAIDEN NAME <u>Eva Mason</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Causes Unknown</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 22</u> , 19 <u>60</u> , to <u>May 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>60</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward T. Schnoor</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> PHYSICIAN'S NAME (Type) <u>Edward T. Schnoor</u> <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 8 - 1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Plot</u>		22d. LOCATION (City, town, or county) (State) <u>Deale C & C Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor - San Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 9 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

13831

CERTIFICATE OF DEATH

13831

13



13



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6512 Brighton Ave., Baltio. 7</u>				d. STREET ADDRESS <u>6512 Brighton Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>Lee</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> , Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 7, 1952</u>		9. AGE (In years last birthday) <u>7</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Henery Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Louise Turnbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Baltimore 7, Md.</u> <u>Mrs. Dorothy L. Anderson, 6512 Brighton Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured hemangioma - brain</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>60</u> , to <u>May 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>60</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.				ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u>		DATE SIGNED <u>May 11, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Clarence E. McWilliams</u>				<u>Reisterstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Nend, Pikesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2413
CENTRAL WARE OF DEPT. OF HEALTH
BUREAU OF VETERINARY MEDICINE

ADULT 6-11-16-18-20-22-24-26-28-30-32-34-36-38-40-42-44-46-48-50-52-54-56-58-60-62-64-66-68-70-72-74-76-78-80-82-84-86-88-90-92-94-96-98-100

11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

11



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3414 **CERTIFICATE OF DEATH** **05382**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 20 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 Braeside Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond D. Anderson				4. DATE OF DEATH Month May Day 30 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1893	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer, U.S. Gov't		10b. KIND OF BUSINESS OR INDUSTRY Ind.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert Anderson			
14. MOTHER'S MAIDEN NAME Josephine Weaver				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes			
16. SOCIAL SECURITY NO. WW 1				17. INFORMANT Mrs. Bessie M. Anderson, 613 Braeside Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery occlusion DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that (I) (this hospital) attended the deceased from April 14, 1956 to May 30, 1960 , that (I) (we) last saw the deceased alive on May 28, 1960 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harry L. Knipp</i>				22b. DATE SIGNED 5/31/60		22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M. D.	
22d. ADDRESS 4116 Edmondson Avenue				22e. ADDRESS Balto. 29, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk.		23d. LOCATION (City, town, or county) (State) Baltimore 7, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave				25a. REC'D BY REGISTRAR DATE JUN 1 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



Baltimore

Catonsville

20 yrs

Catonsville

Mr.

Baltimore

615 Wrentham St.

615 Wrentham St.

Raymond E. Anderson

May 30/60

Male

July 14, 1893

Robert Anderson

Jessamine Weaver

Yes

None

Mrs. Jessie M. Anderson, 615 Wrentham St.



Burial 5/60

Baltimore, Md.

11200 E. 9th Edmondson Ave

May 1 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5415

CERTIFICATE OF DEATH

05383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Owings Mills</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills</u>			
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Garrison Forrest Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>McNair</u> Last <u>Annan</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1873</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Emmitsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel McNair</u>				14. MOTHER'S MAIDEN NAME <u>Antoinette Moritz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Cwings Mills, Md.</u> <u>Mr. Richard C. Annan, Garrison Forrest Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured, Dissecting Aneurysm</u> DUE TO (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u>Chronic Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>May 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>60</u> , and that death occurred at <u>12:24 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u>				ADDRESS (Street, city or town, state) <u>11904 Reisterstown Rd., Reisterstown Md.</u> DATE SIGNED <u>May 2 1960</u>			
PHYSICIAN'S NAME (Type) <u>Clarence E. McWilliams</u>				ADDRESS <u>11904 Reisterstown Rd., Reisterstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

100

5416

CERTIFICATE OF DEATH

05384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite				c. LENGTH OF STAY IN 1b 14 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michael Middle Askar Last Askar				4. DATE OF DEATH Month May Day 16th. Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1877	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.		IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Street Car		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓	
13. FATHER'S NAME Andrew Askar				14. MOTHER'S MAIDEN NAME Eleanora Zenk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-14-2120		INFORMANT Address Mrs. Berta Askar Summit Ave. Granite, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Suggestive Heart Disease (c) 5 yrs.				INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1954 to May 16, 1960 , that I last saw the deceased alive on May 13, 1960 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L. Pierpont M.D.				DATE SIGNED 5/17/60			
PHYSICIAN'S NAME (Type) Edwin L. Pierpont M. D.				8204 Liberty Rd. Baltimore - 7, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Alphonsus		22d. LOCATION (City, town, or county) (State) Woodstock, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons ADDRESS Catonsville, Md.				24a. REC'D BY REGISTRAR MAY 20 '60		24b. REGISTRAR'S SIGNATURE C. L. S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0330

OFFICE OF THE

1910



[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5417 CERTIFICATE OF DEATH 05385

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3325 Offutt Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3701.4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>2313 Annapolis Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>L.</u> Last <u>BAGOT</u>		4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1882</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Nathan Lilly</u>		14. MOTHER'S MAIDEN NAME <u>Rose Woodward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-01-8350</u>	
17. INFORMANT <u>Mrs. Harry O. Knipp - 3325 Offutt Rd.</u>		Address <u>Randalls town</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Secondary anemia due to severe unexplained gastro-intestinal hemorrhage</u> DUE TO (c) <u>Hypertensive arterio-sclerotic cardio vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 3, 1950</u> to <u>May 11, 1960</u> that (I) (we) last saw the deceased alive on <u>May 11, 1960</u> , and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George A. Knipp</u>		22b. DATE SIGNED <u>May 12, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>George A. Knipp, M. D.</u>		22d. ADDRESS <u>4116 Edmondson Avenue Balto. 29, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/14/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Boudon Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto. 17, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 12 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

DEPT

CERTIFICATE OF DEATH

1917



event, within

VR A15 (4)
15M 9/59

event, within

5418

05386

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>11 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>601 Anneslie Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Leslie</u> First Middle Last <u>Wayne Baker</u>		4. DATE OF DEATH <u>May 21</u> 19 <u>60</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Certified Public Accountant</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Isaac Baker</u>		14. MOTHER'S MAIDEN NAME <u>Jennie E Moulton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-36-9739</u>	
17. INFORMANT <u>Mr Wendall Baker</u>		Address <u>5803 Kenmore Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 10</u> 19 <u>56</u> to <u>May 21</u> 19 <u>60</u> . that (I) (we) saw the deceased alive on <u>May 21</u> 19 <u>60</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Laurence C. Post</u>		22b. DATE SIGNED <u>5-21-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		22d. ADDRESS <u>6805 York Rd. Baltimore 12 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL</u>	23d. LOCATION (City, town, or county) (State) <u>Towson MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS & SONS Co.</u>		25a. REC'D BY REGISTRAR <u>MAY 23 '60</u>	
ADDRESS <u>4905 YORK RD. BALTO.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

05880

05880

(1)

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "James", "Katherine", and "May" are faintly visible.]

1/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5419

CERTIFICATE OF DEATH

05387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ada</u> First <u>V</u> Middle <u>Ballard</u> Last		4. DATE OF DEATH <u>May</u> Month <u>20</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1869</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Shawhan, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Chilcoat</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>COLLEGE MANOR HOME LUTHERVILLE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minute</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>about May 15</u> , 19 <u>60</u> , and that death occurred at <u>2:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest C Brown Jr</u>		ADDRESS (Street, city or town, state) <u>401 N. Calvert St</u> DATE SIGNED <u>May 20, 1960</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 23, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. JENKINS & SONS</u>		ADDRESS <u>4405 YORK RD BALT 12, MD</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 20 1960</u>			

1952

CERTIFICATE OF DEATH

1952

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5420 CERTIFICATE OF DEATH 05388

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 16 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last BARNES				4. DATE OF DEATH Month May Day 25 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1928	
9. AGE (In years last birthday) 32 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Constructions		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John J. Barnes		14. MOTHER'S MAIDEN NAME Mary A. Kroth		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or years of service) Yes WW II	
16. SOCIAL SECURITY NO. 215-22-7610		17. INFORMANT Clinical Records Address VAH, Baltimore 18, Md. Fort Howard Division		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS 522X XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) JAUNDICE AND CHRONIC PANCREATITIS DUE TO PORTAL CIRRHOSIS OF THE LIVER (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (a) (this hospital) attended the deceased from May 9 19 60 , to May 25 19 60 , that (b) (we) last saw the deceased alive on May 25 19 60 , and that death occurred at 6:40 P. M. from the causes and on the date stated above.	
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.		22b. DATE SIGNED 5/26/60		22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Denny Inc. ADDRESS Light & Montgomery Sts. Baltimore, Maryland		25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Haines			

8260

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00330

CERTIFICATE OF STATE

1951

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5423

CERTIFICATE OF DEATH

05392

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 104 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1938 E. Lafayette Avenue			
3. NAME OF DECEASED (Type or print) First JAMES Middle D. Last BETHEA				4. DATE OF DEATH Month May Day 22 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1919	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Durham, N. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Howard Bethea				14. MOTHER'S MAIDEN NAME Betty McNeill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 237-28-2340		17. INFORMANT Address Clin/Rec. VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER WITH REMOTE METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) 181.0 INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 8, 1960 to May 22, 1960 that (I) (we) last saw the deceased alive on May 22, 1960 , and that death occurred at 8:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.				22b. DATE SIGNED 5/23/60			
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.				22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneib	

025385

CERTIFICATE OF DEATH

025385



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SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
DATE OF DEATH
PLACE OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF THE REGISTRAR
COUNTY OF
STATE OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5424 CERTIFICATE OF DEATH

05393
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>22</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Dundalk.</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7526 Battle Horse circle</u>				d. STREET ADDRESS <u>#1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MICHAEL JOSEPH BILY</u>				4. DATE OF DEATH Month Day Year <u>MAY 5 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1892</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clothing mfg</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bily</u>				14. MOTHER'S MAIDEN NAME <u>Marie Primus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>212-16 0213</u>		17. INFORMANT Address <u>MARY BILY (WIFE)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Glomerular nephritis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>diabetes mellitus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>4 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 8</u> , 19 <u>56</u> to <u>May 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.				ADDRESS (Street, city or town, state) <u>6908 N. POINT Rd</u>		DATE SIGNED <u>5/5/60</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN M.D.</u>				<u>BALTO-19-MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bohemian National Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimmek Funeral Home, Inc.</u> <u>2601-3-5 E. Madison St.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5425

Reg. Dist. No. 05394

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eccleston</u>			c. LENGTH OF STAY IN 1b <u>X</u> <u>Eccleston</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Park Heights Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Whitridge</u> Last <u>Blackford</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1876</u>		9. AGE (In years last birthday) yrs. <u>83</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>			
13. FATHER'S NAME <u>John A. Whitridge</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Henderson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Bartlett F. Johnston Eccleston, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis.</u> <u>420.1</u> DUE TO <u>complete heart block. A-V dissociated 2 months.</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>arteriosclerosis</u> (c) <u>20 years.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 years.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Mar 7</u> , 19 <u>47</u> to <u>May 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>60</u> , and that death occurred at <u>5 A.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>1725 Ruxton Rd. Baltimore 8. Md.</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>PALMER F. C. Williams</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>5-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05395

Reg. Dist. No.

5426

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6805 Beech Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle L. Last Bodenschatz		4. DATE OF DEATH Month May Day 8 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 8 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Karl Bodenschatz		14. MOTHER'S MAIDEN NAME Margareta Geyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-2944	
17. INFORMANT Mrs. Anna M. Hobbs		Address 4601 Ridgeway Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 420.1 MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 10 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 17 , 19 55 , to MAY 8 , 19 60 , that I last saw the deceased alive on April 26 , 19 60 , and that death occurred at 2 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon J. Lewis		ADDRESS (Street, city or town, state) 6732 BELAIR ROAD BALTIMORE 6, Md	
PHYSICIAN'S NAME (Type) ADAM C. SWISS		DATE SIGNED May 9, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-12-1960	22c. NAME OF CEMETERY OR CREMATORY Jerusalem Lutheran	22d. LOCATION (City, town, or county) (State) Belair Rd. Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Jim Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE MAY 10 '60		24b. REGISTRAR'S SIGNATURE Charles E. Hearn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05307

CERTIFICATE OF DEATH

2523

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF BIRTH: _____

PLACE OF DEATH: _____

Cause of Death: _____

Signature: _____

Official Seal: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5427
CERTIFICATE OF DEATH

05396

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summitt Nursing Home, 98 Smithwood Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John C. Bonicker		4. DATE OF DEATH May 25/60	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 12, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -----Bonicker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213 10 2591	
17. INFORMANT Paul V. Bonicker		Address 1252 Maple Ave Arbutus	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis & Meningeal Abscess DUE TO (b) Cervical Arter. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laminectomy Cervical Arter. Perforated Ulcers		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/21/60 to 5/25/60 , that (I) (we) last saw the deceased alive on 5/24/60 , and that death occurred 6:55 AM from the causes and on the date stated above.			
22a. SIGNATURE W E McGraw M.D.		22b. DATE SIGNED 5/26/60	
22c. PHYSICIAN'S NAME (Type) W E McGraw M.D.		22d. ADDRESS 1303 Frederick Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 28/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) Balto. 29 Ma	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101		25a. REC'D BY REGISTRAR Edmondson Ave.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAY 31 '60	

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CERTIFICATE OF DEATH

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Baltimore

MA.

Catonsville

Arbutus

2001st Nursing Home, 28 Smithwood Ave 1952 Maple Ave

John C. Honicker

Male xx Apr. 18, 1954 78

Retired Baltimore, Francis Co. Md. USA

Unknown

212 10 2521 Paul V. Honicker, 1252 Maple Ave Arbutus

Handwritten notes:
Honicker, Paul V.
Arbutus

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Honicker, Paul V.
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Honicker, Paul V.
Arbutus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
15M 9/59

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5428
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05397

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 8 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS BALTIMORE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JANE Middle Last BOOTH		4. DATE OF DEATH Month MAY Day 20 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1872
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S	
13. FATHER'S NAME CHARLES W. RUTLEDGE		14. MOTHER'S MAIDEN NAME JANE POOLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic Cardiac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-16-1960 to 5-20-1960 , that (I) (we) last saw the deceased alive on 5-20-1960 , and that death occurred at 5:30 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5/20/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24, 1960	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
25a. REC'D BY REGISTRAR MAY 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5429

CERTIFICATE OF DEATH

05398

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3001.4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 856 West Baltimore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK C. BOYD		4. DATE OF DEATH Month May Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 31, 1905
9. AGE (In years last birthday) 55		10. IF UNDER 1 YEAR Months 5 Days 18 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Shipyards	
11. BIRTHPLACE (State or foreign country) Whittier, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Boyd		14. MOTHER'S MAIDEN NAME Maggie Carver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-03-9726	
17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. X DIVERTICULITIS (b) UNKNOWN (c) 3 DAYS		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 16 2:18 to May 18 1960 , that (I) (we) last saw the deceased alive on May 18 1960 , and that death occurred at A. M. from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE 5/18/60	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, 2601 E. Madison St.		25a. REC'D BY REGISTRAR DATE MAY 20 '60	
ADDRESS Baltimore, Md.		25b. REGISTRAR'S SIGNATURE Charles L. Hanks	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05399

60-0571

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 4 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30, Maryland d. STREET ADDRESS 646 W. Barre Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Junior Last Bradford		4. DATE OF DEATH Month 5 Day 26 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/59
9. AGE (In years last birthday) 9		10. IF UNDER 1 YEAR Months 9 Days 26 Hours 19 Min. 60	11. IF UNDER 24 HRS. 19 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Bradford		14. MOTHER'S MAIDEN NAME Dorothy Mary Frances Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Rosewood Records		Address Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Non-Compensated Hydrocephalus (increased intracranial pressure) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) intracranial pressure DUE TO (c) Anemia INTERVAL BETWEEN ONSET AND DEATH 4/19/60 3-weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25/60 , 19____, to 5/26/60 , 19____, that I last saw the deceased alive on 5/26/60 , 19____, and that death occurred at 11:55pM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rosewood Tr. School DATE SIGNED 5/27/60			
ACTUAL SIGNATURE John Pappas M.D. R. U. Hoy		DATE SIGNED 5/27/60	
PHYSICIAN'S NAME (Type) John Pappas, M.D.		ADDRESS Owings Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/60	
22c. NAME OF CEMETERY OR CREMATORY MT. CALvary Cem.		22d. LOCATION (City, town, or county) (State) Georgetown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson		ADDRESS 1000 Branthwy Ave	
24a. REC'D BY REGISTRAR DATE JUN 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2031203XV6

00390

CERTIFICATE OF DEATH

00390

00390



[Faint, mostly illegible text on a form with horizontal lines. Some legible fragments include:]

NAME OF DECEASED _____

DATE OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

[The form contains several lines of text, many of which are too faint to transcribe accurately.]



1



200100390

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5431 CERTIFICATE OF DEATH

05400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sparrows Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>11007 J. St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Willis Brooks Jr.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1896</u>
9. AGE (In years) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>30</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steelworker</u>	
11. BIRTHPLACE (State or foreign country) <u>Atlanta Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Willis Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Addie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen C. Brooks</u>		Address <u>1007 J. St. Sparrows Pt.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>1 hour</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>0</u> a. m. <u>19</u> p. m.	Month <u>May</u> Day <u>25</u> Year <u>1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f. (City or town) <u>Balto.</u>		(County) <u>Md.</u> (State)	
21. I certify that I attended the deceased from <u>January 1, 1959</u> to <u>May 25, 1960</u> , that I last saw the deceased alive on <u>May 25, 1960</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Thomas</u>		ADDRESS (Street, city or town, state) <u>107 N. Main St. - Balto. Md.</u>	
DATE SIGNED <u>May 27, 1960</u>			
PHYSICIAN'S NAME (Type) <u>J. H. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 31, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank T. Ellickson</u>		ADDRESS <u>129 N. Caroline St.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5432 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 HILLSIDE AVE.		d. STREET ADDRESS 15 HILLSIDE AVE	
3. NAME OF DECEASED (Type or print) MARIE W. BRUFF		4. DATE OF DEATH Month MAY Day 31 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 9 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB WOHLGEMUTH		14. MOTHER'S MAIDEN NAME MARGARET GERHOLD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE.	
17. INFORMANT MR. CARL BRUFF (SON)		Address 15 HILLSIDE AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4:20 PM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from Nov 3 1955 to May 31 1960 , that (I) first last saw the deceased alive on May 27 1960 , and that death occurred at 12 M from the causes and on the date stated above.			
22a. SIGNATURE A. S. Chalcraft M.D.		22b. DATE SIGNED June 2, 1960	
22c. PHYSICIAN'S NAME (Type) Dr. A. S. CHALCRAFT		22d. ADDRESS 6310 York Rd Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JUNE 3, 1960	23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY	23d. LOCATION (City, town, or county) (State) BALTIMORE COUNTY, M.D.
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS CO		25a. REC'D BY REGISTRAR DATE MAY 2 '60	
ADDRESS 4905 York Road, Bldg 12		25b. REGISTRAR'S SIGNATURE Anthony L. Thomas	

05401

CERTIFICATE OF DEATH

1933

(14)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8000 Mid-Haven Road		2. USUAL RESIDENCE (Where deceased lived, If institution: Reside before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 518 N. Decker Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH Frank BUCZKOWSKI		4. DATE OF DEATH Month May Day 30 Year 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1923	
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 36 Days 36	
11. IF UNDER 24 HRS. Hours 36 Min. 36		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Buczkowski		14. MOTHER'S MAIDEN NAME Mary E. Sewell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. 219-14-0313	
17. INFORMANT Audrey E. Grabarek		Address 609 S. Robinson St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab Wound of Chest. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Stabbed during altercation.		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 30 1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) (County) (State) Dundalk Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/31/60	
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county) 2007 Eastern Ave	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/60	
22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or country) (State) Balto. Md.	
23. FUNERAL DIRECTOR Wm. S. Fialkowski		24a. REC'D BY REGISTRAR DATE JUN 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			



2388

12/10/41

12/10/41

1000 Mid-Haven road

JOHN E. BROWN

late

Special Operator

JOHN E. BROWN

1

22nd Street, New York

Stopped during attention.

xxx May 30 60

1000

1000

1000

1000

Charles E. Brown

12/10/41

1000

1000

5433

CERTIFICATE OF DEATH

05404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>N.C.</u> b. COUNTY <u>Durham</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>John</u> Last <u>Burger</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Burger</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Senft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Central thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <u>Central arteriosclerosis</u> DUE TO (c) <u>Branch pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>~ 7 days</u> <u>yes -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Branch pneumonia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>60</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest C. Brown Jr.</u>				ADDRESS (Street, city or town, state) <u>1101 N. Calvert St. Balt. 2</u>			
PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u>				DATE SIGNED <u>5/20/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN O. MITCHELL & SONS, INC., 1900 EUTAW PL.</u>				24a. REC'D BY REGISTRAR <u>MAY 23 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

1101 N. 1st St.

St. Louis, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **05405**

5435

1. PLACE OF DEATH a. COUNTY Baltio. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 3101.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 528 W. Mulberry Street	
3. NAME OF DECEASED (Type or print) First Ella Middle Genevieve Last Cannon		4. DATE OF DEATH Month May Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY PANAMA FACTORY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Cannon		14. MOTHER'S MAIDEN NAME Margaret Dougherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-03-9256	
17. INFORMANT MRS MARY B. GEPP		Address 530 W. MULBERRY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis chronic 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 5, 1957 to May 10, 1960 , that I lost saw the deceased olive on May 9, 1960 , and that death occurred at 4:15 PM , from the causes and on the date stated above. DATE SIGNED ADDRESS (Street, city or town, state) Charles F O'Donnell M.D. 7501 York Rd - Towson 5/10/60			
ACTUAL SIGNATURE Charles F O'Donnell		PHYSICIAN'S NAME (Type) Charles F O'Donnell M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/12/60	22c. NAME OF CEMETERY OR CREMATORY New Catholic	22d. LOCATION (City, town, or county) (State) Catonsville Md
23. FUNERAL DIRECTOR'S SIGNATURE J. Shatter		ADDRESS Explan 5404 Belair Rd	
24a. REC'D BY REGISTRAR MAY 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

JAMIE BROWN

NAME OF DECEASED		JAMIE BROWN	
AGE		25	
SEX		Male	
RACE		White	
DATE OF DEATH		1-15-1925	
PLACE OF DEATH		Baltimore, Maryland	
CAUSE OF DEATH		Pneumonia	
MANNER OF DEATH		Natural	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF NEXT OF KIN		[Signature]	
SIGNATURE OF BURIAL OFFICER		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
SIGNATURE OF CLERK		[Signature]	
SIGNATURE OF JUDGE		[Signature]	
SIGNATURE OF SHERIFF		[Signature]	
SIGNATURE OF DISTRICT ATTORNEY		[Signature]	
SIGNATURE OF COUNTY CLERK		[Signature]	
SIGNATURE OF CITY CLERK		[Signature]	
SIGNATURE OF VICE MAYOR		[Signature]	
SIGNATURE OF MAYOR		[Signature]	

Reg. Dist. No.

VS A1S (4)
1SM 9/5B

000000

CERTIFICATE OF DEATH

#1338

DATE OF DEATH

10/10/1977

PLACE OF DEATH

WILSON, N.C.

DECEASED'S NAME

JOHN, JR.

DATE OF BIRTH

10/10/1977

PLACE OF BIRTH

WILSON, N.C.

DECEASED'S SEX

DATE OF DEATH

10/10/1977

1

[Faint, mostly illegible text from the reverse side of the document, including names and dates.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05407

5437

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 17yr6mth16dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 223 North High Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Louise Middle Carter Last Carter		4. DATE OF DEATH Month May Day 13 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1896
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months 03 Days 00 Hours 00 Min. 00	IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Andrew Myers	
14. MOTHER'S MAIDEN NAME Emma Henderson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach (Linitis plastica) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 151X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident - Generalized arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 14, 1959 to May 13, 1960 , that I last saw the deceased alive on May 13, 1960 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-19-60	
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/20/60	22c. NAME OF CEMETERY OR CREMATORY Cathedral	22d. LOCATION (City, town, or county) (State) 430000 Frederick
23. FUNERAL DIRECTOR'S SIGNATURE John J. [Signature]		24. REC'D BY REGISTRAR 1318 Light	
25. REGISTRAR'S SIGNATURE Arthur S. [Signature]		26. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE COMPASS
FARM BOLD

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

00107

113

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York City	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Farmer		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1945		10:30 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Physician		Hospital	
Jan 16, 1945		11:00 AM		Home		Dr. Smith		St. Mary's	

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

5389

05408

32

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place) <u>1 yr. 3 m. 12 d</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City 6 3014</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>4803 Burland Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>THOMAS GAETANA CASA SR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 5 19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1. 3. 1888.</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Louis Casa</u>				14. MOTHER'S MAIDEN NAME <u>Lucille Dicark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>215-10-1782</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
022X IMMEDIATE CAUSE (A) <u>Ruptured aortic aneurism</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Far advanced bilateral cavity pulmon. TB active</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1. 23</u> , 19 <u>59</u> , to <u>5. 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5. 5</u> , 19 <u>60</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>Mt. Wilson, Maryland</u>			
DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5/9/60</u>		DATE THEREOF <u>5/9/60</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAY 9 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard G. Runk</u>		ADDRESS <u>2205 Park Rd</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5438

CERTIFICATE OF DEATH

05409
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 22 Westchester Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY N CAVEY				4. DATE OF DEATH Month Day Year May 30, 1960 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ilchester, Md		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Patrick Durbin				14. MOTHER'S MAIDEN NAME Gelen Mc Guirk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Emmet Cavey, Ellicott City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse DUE TO Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Carcinoma, uterus							INTERVAL BETWEEN ONSET AND DEATH 15 min 30 min 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 25 , 19 60 to May 30 , 19 60 , that I last saw the deceased alive on May 27 , 19 60 , and that death occurred at 4:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Thomas J. Herbert , M.D. ADDRESS (Street, city or town, state) 46 Church Rd. DATE SIGNED 5-30-60 PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D. Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE JUN 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1932

Birthplace

Married

Age

Elizabethtown

Married

2 Westchester Ave.

One in the line

1901, 1902

CAUSE

NEW

72

1901-1902

1902

White

Female

Elizabethtown, Pa.

At home

John W. Smith

Married

Elizabethtown, Pa.

Home

No

Elizabethtown, Pa.

1901-1902

1901

Elizabethtown, Pa.

5439

CERTIFICATE OF DEATH

05410
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAYNESVILLE MD.		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAYNESVILLE MD.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9011 SATYR HILL RD.				d. STREET ADDRESS 9011 SATYR HILL RD.			
3. NAME OF DECEASED (Type or print) First SOPHIA Middle D Last CLASS.				4. DATE OF DEATH Month MAY Day 18 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1880		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK WHOLER				14. MOTHER'S MAIDEN NAME WILHELMENIA DORU			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. NONE.		INFORMANT Address W DEEMER CLASS 9011 SATYR HILL RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, chronic. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 Hrs. at least 25 yrs.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 Oct , 19 50 , to 18 May , 19 60 , that I last saw the deceased alive on 18 May , 19 60 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edward L. J. Molz M.D. 7425 Harford Rd. 20 May 60. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) EDWARD L. J. MOLZ, M.D. Baltimore (14) Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/21/60.		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		22d. LOCATION (City, town, or county) (State) BALTO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Sarah Funeral Home 7401 Belair Rd #6 MD				24a. REC'D BY REGISTRAR MAY 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05210

CERTIFICATE OF DEATH

5233



State of Maryland
County of Baltimore
I, the undersigned, being a duly qualified physician, do hereby certify that
the within and above named person died at the residence of the deceased
on the 10th day of May, 1924, at the age of 75 years, of the
effects of a long illness.
Witness my hand and the seal of my office this 10th day of May, 1924.
Frederick W. Jones, M.D.
Physician

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5440

Items 8, 13 & 14 Film G262 5/13/60 iwk

CERTIFICATE OF DEATH

05411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eastonsville</i>				c. LENGTH OF STAY IN 1b <i>3601.4</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>House in Lines</i>				d. STREET ADDRESS <i>3808 Menlo Drive</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Cluster</i> Last <i>Cluster</i>				4. DATE OF DEATH Month <i>5-</i> Day <i>8-</i> Year <i>1960</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>unknown 1886</i>	
9. AGE (In years lost birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>4</i>		IF UNDER 24 HRS. Hours <i>7</i> Min. <i>4</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Moving Pictures</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Abraham Cluster</i>				14. MOTHER'S MAIDEN NAME <i>Hannah unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Rose Cluster - same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>?</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Abscess 4 weeks prior</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>5/6</i> , 19 <i>60</i> , to <i>5/8</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/8</i> , 19 <i>60</i> , and that death occurred at <i>4 P</i> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Herb J. Miller</i>				ADDRESS (Street, city or town, state) <i>1047 Highland Ave</i> DATE SIGNED <i>5/9/60</i>			
PHYSICIAN'S NAME (Type) <i>Herb J. Miller</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-10-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i>		22d. LOCATION (City or town, or county) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i> ADDRESS <i>Mc 2100 Eutan Place</i>				24a. REC'D BY REGISTRAR DATE <i>MAY 10 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

MEDICAL CERTIFICATION

1150

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05412

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridderwood</u>		c. LENGTH OF STAY IN 1b <u>6 Mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7922 ROLDREW AVE.</u>				d. STREET ADDRESS <u>613 Glenwood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Marie</u> Last <u>Connolly</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1895</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John G. Mansfield</u>				14. MOTHER'S MAIDEN NAME <u>Annie Potts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Charlotte C. Hook</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma toxic</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of colon - removed</u> DUE TO <u>Nov. 14, 1959</u> (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 15, 1957</u> to <u>May 2, 1960</u> , that (I) (we) last saw the deceased alive on <u>Apr. 29, 1960</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederick J. Vollmer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/3/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>				22d. ADDRESS <u>6100 York Rd Balto-12</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 5, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u>				ADDRESS <u>4905 York Road</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 4 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>William J. Hume</u>			

05413

CERTIFICATE OF DEATH

05413

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]

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05413

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Marriottsville</u>		c. LENGTH OF STAY IN 1b <u>Rife</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Marriottsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Ward's Chapel Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Triplitt Conroy</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1866</u>		9. AGE (In years lost birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instrument dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm machinery</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry S. Conroy</u>				14. MOTHER'S MAIDEN NAME <u>Angeline Triplitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. W. F. Conroy - Marriottsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/4/60</u> 19 <u> </u> to <u>5/4/60</u> 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>5/4/60</u> 19 <u> </u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. E. Martin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-5-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. E. MARTIN</u>				22d. ADDRESS <u>RANDALLSTOWN, MD.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-7-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ward's Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Tikvah, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				ADDRESS <u>Ward's Ridge, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 10 1960</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05414

5390

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 117 Honeysuckle Court				d. STREET ADDRESS 117 Honeysuckle Court			
3. NAME OF DECEASED (Type or print) Ella		First Louise		Middle Cowling		Last May	
4. DATE OF DEATH May 23 1960		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 15, 1927		9. AGE (in years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Smithfield, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charlie Ensley			
14. MOTHER'S MAIDEN NAME Mattie Bailey				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 220-20-9096				17. INFORMANT Anthony T. Cowling - 117 Honeysuckle Court			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Card. - Vascular Renal DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min 5 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE JACK C. COLLINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-23-60			
EXAMINER'S NAME (Type) JACK C. COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-27-60		22c. NAME OF CEMETERY OR CREMATORY Chuckatuck Cemetery		22d. LOCATION (City, town, or county) (State) Nasamond Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802 Madison Avenue		24a. REC'D BY REGISTRAR MAY 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5443

CERTIFICATE OF DEATH

Reg. Dist. No.

05415

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>				c. LENGTH OF STAY IN 1b <u>35</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1905 ENGLEWOOD AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH CHASE CROSSLEY</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 1, 1882</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES G. CHRISTHILL</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. CHASE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-12-3224</u>			
17. INFORMANT <u>DAUGHTER - RUTH GOODY</u>				Address <u>1905 ENGLEWOOD AVE - BALTO, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIABETES MELLITUS.</u> DUE TO <u>10 YEARS</u> (c) <u>CONGESTIVE HEART FAILURE</u> <u>ONE YEAR</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IN ANTION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>DECEMBER 10, 1950</u> to <u>MAY 28, 1960</u> , that I last saw the deceased alive on <u>MAY 6, 1960</u> , and that death occurred at <u>10:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin Pierpont</u>				ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD BALTO, MD</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN P. PIERPONT, MD</u>				DATE SIGNED <u>5/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 31, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.T. STANSBURY</u>				ADDRESS <u>6411 Warden Mill</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05416

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HONG GREEN</u>				c. LENGTH OF STAY IN 1b <u>8 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MANOR ROAD Box 208</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>M.</u> Last <u>CULVER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 NOVEMBER 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TOWSON MD</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam C. Krout</u>				14. MOTHER'S MAIDEN NAME <u>Martha M. Switzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Box 208</u> <u>L. MARGARETTA WILLIAMS MANOR RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>18 MAY 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Walters</u> ADDRESS <u>Pratt & Spricker Sts</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5445

Item 2 Film G263 5-19-60 et

CERTIFICATE OF DEATH

05417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 yr. 5 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent 1001 West Joppa Road.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Teresa C. Cunningham		4. DATE OF DEATH May 3rd. 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Cunningham		14. MOTHER'S MAIDEN NAME Margaret Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Road, Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Failure - Chronic DUE TO ASCV Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Senile Changes DUE TO Senile Changes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/16 , 19 60 , to 5/3 , 19 60 , that I last saw the deceased alive on 5/13 , 19 60 , and that death occurred at 9:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Victor F. King		ADDRESS (Street, city or town, state) 1102 East Joppa Road, Towson, Md. DATE SIGNED 5/13/60	
PHYSICIAN'S NAME (Type) Victor F. King, M.D.		1102 East Joppa Road, Towson, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/60	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lemmon		ADDRESS 4611 Park Heights Ave. Balto.	
24a. REC'D BY REGISTRAR MAY 5 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5448

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05418

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
c. LENGTH OF STAY IN 1b 20 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1566 Ridgley Street (30) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 1566 Ridgley Street		
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES --- DELL			4. DATE OF DEATH Month Day Year May 10 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1887	9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker			10b. KIND OF BUSINESS OR INDUSTRY Railroad Company		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Dell			14. MOTHER'S MAIDEN NAME Mary Schmidt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. ---		
17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Baltimore 18, Md.			Address Fort Howard Div.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 60020 PYELONEPHRITIS, CHRONIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UREMIC PERICARDITIS (c) ARTERIOSCLEROSIS, GENERALIZED					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 2 WEEKS UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 20, 1960 to May 10, 1960 , that (he) last saw the deceased alive on May 10, 1960 , and that death occurred at 7:40 A. M., from the causes and on the date stated above.					
22a. SIGNATURE John D. Talbert			22b. DATE SIGNED 5/10/60		
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.			22d. ADDRESS BALTIMORE 18, Maryland VAH, FORT HOWARD DIVISION		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore 28, Maryland		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Miller			25a. REC'D BY REGISTRAR May 13 '60		
25b. REGISTRAR'S SIGNATURE William J. Frank					

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND												2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere d. STREET ADDRESS 2706 Lodge Farm Road																																																											
3. NAME OF DECEASED (Type or print) JUANITA (BARNES) DENNIS												4. DATE OF DEATH May 28 1960																																																											
5. SEX Female				6. COLOR OR RACE Colored				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Nov 21 1922				9. AGE (In years last birthday) 37 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.																																															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife												10b. KIND OF BUSINESS OR INDUSTRY Bald. ms												12. CITIZEN OF WHAT COUNTRY?																																															
13. FATHER'S NAME Frank Baylor												14. MOTHER'S MAIDEN NAME Mary												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No												16. SOCIAL SECURITY NO. 322.0												17. INFORMANT Theodore Baylor Address																							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PENDING/ Acute Alcoholism DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)												20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>																																																																							
ACTUAL SIGNATURE William J. Jones												M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>												DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED May 28, 1960																																			
EXAMINER'S NAME (Type)												Address (Street, city, town, or county)												22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF 6-2-60												22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.												22d. LOCATION (City, town, or country) (State) A. A. County Md											
23. FUNERAL DIRECTOR Milton E. Elickson												ADDRESS 1129 N. Calhoun St												24a. REC'D BY REGISTRAR JUN 2 '60												24b. REGISTRAR'S SIGNATURE Arthur S. Hanna																																			

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POST MEDICAL EXAMINATION CERTIFICATE OF DEATH

THE STATE
OF NEW YORK



Signature of

Physician

Signature of

Signature of

Signature of

2500 10th Ave. N.Y.C.

2500 10th Ave. N.Y.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5448

CERTIFICATE OF DEATH

Reg. Dist. No.

05420

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6435 Gilmore St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard S. Devilbiss		4. DATE OF DEATH Month May Day 17 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1869
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Penn. Rail Rd.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Devilbiss		14. MOTHER'S MAIDEN NAME Deborah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Laura M. Devilbiss		Address 6435 Gilmore St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Acc DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15 , 19 60 , to 5/17 , 19 60 , that I last saw the deceased alive on 5/16/60 , 19 60 , and that death occurred at 8 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6410 Windsor Mill Rd Baltimore Md. DATE SIGNED			
ACTUAL SIGNATURE Milton Schlenoff M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Milton Schlenoff MD		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stansbury		24a. REC'D BY REGISTRAR DATE MAY 18 '60	
ADDRESS 6411 Windsor Mill Rd.		24b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

1918

1918

<p>1. Name of deceased: JOHN W. DAVIS</p>		<p>2. Sex: Male</p>	
<p>3. Age: 45</p>		<p>4. Date of death: Jan 15 1918</p>	
<p>5. Place of death: Home</p>		<p>6. Cause of death: Heart Disease</p>	
<p>7. Occupation: Teacher</p>		<p>8. Usual place of abode: Home</p>	
<p>9. Name of physician: Dr. J. H. Smith</p>		<p>10. Name of undertaker: John W. Davis</p>	
<p>11. Name of funeral home: John W. Davis</p>		<p>12. Name of cemetery: John W. Davis</p>	
<p>13. Name of minister: John W. Davis</p>		<p>14. Name of sexton: John W. Davis</p>	
<p>15. Name of registrar: John W. Davis</p>		<p>16. Name of coroner: John W. Davis</p>	
<p>17. Name of jury: John W. Davis</p>		<p>18. Name of jury: John W. Davis</p>	
<p>19. Name of jury: John W. Davis</p>		<p>20. Name of jury: John W. Davis</p>	
<p>21. Name of jury: John W. Davis</p>		<p>22. Name of jury: John W. Davis</p>	
<p>23. Name of jury: John W. Davis</p>		<p>24. Name of jury: John W. Davis</p>	
<p>25. Name of jury: John W. Davis</p>		<p>26. Name of jury: John W. Davis</p>	
<p>27. Name of jury: John W. Davis</p>		<p>28. Name of jury: John W. Davis</p>	
<p>29. Name of jury: John W. Davis</p>		<p>30. Name of jury: John W. Davis</p>	
<p>31. Name of jury: John W. Davis</p>		<p>32. Name of jury: John W. Davis</p>	
<p>33. Name of jury: John W. Davis</p>		<p>34. Name of jury: John W. Davis</p>	
<p>35. Name of jury: John W. Davis</p>		<p>36. Name of jury: John W. Davis</p>	
<p>37. Name of jury: John W. Davis</p>		<p>38. Name of jury: John W. Davis</p>	
<p>39. Name of jury: John W. Davis</p>		<p>40. Name of jury: John W. Davis</p>	
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<p>51. Name of jury: John W. Davis</p>		<p>52. Name of jury: John W. Davis</p>	
<p>53. Name of jury: John W. Davis</p>		<p>54. Name of jury: John W. Davis</p>	
<p>55. Name of jury: John W. Davis</p>		<p>56. Name of jury: John W. Davis</p>	
<p>57. Name of jury: John W. Davis</p>		<p>58. Name of jury: John W. Davis</p>	
<p>59. Name of jury: John W. Davis</p>		<p>60. Name of jury: John W. Davis</p>	
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<p>75. Name of jury: John W. Davis</p>		<p>76. Name of jury: John W. Davis</p>	
<p>77. Name of jury: John W. Davis</p>		<p>78. Name of jury: John W. Davis</p>	
<p>79. Name of jury: John W. Davis</p>		<p>80. Name of jury: John W. Davis</p>	
<p>81. Name of jury: John W. Davis</p>		<p>82. Name of jury: John W. Davis</p>	
<p>83. Name of jury: John W. Davis</p>		<p>84. Name of jury: John W. Davis</p>	
<p>85. Name of jury: John W. Davis</p>		<p>86. Name of jury: John W. Davis</p>	
<p>87. Name of jury: John W. Davis</p>		<p>88. Name of jury: John W. Davis</p>	
<p>89. Name of jury: John W. Davis</p>		<p>90. Name of jury: John W. Davis</p>	
<p>91. Name of jury: John W. Davis</p>		<p>92. Name of jury: John W. Davis</p>	
<p>93. Name of jury: John W. Davis</p>		<p>94. Name of jury: John W. Davis</p>	
<p>95. Name of jury: John W. Davis</p>		<p>96. Name of jury: John W. Davis</p>	
<p>97. Name of jury: John W. Davis</p>		<p>98. Name of jury: John W. Davis</p>	
<p>99. Name of jury: John W. Davis</p>		<p>100. Name of jury: John W. Davis</p>	



RECEIVED
JAN 15 1918
BALTIMORE

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5449

CERTIFICATE OF DEATH

Reg. Dist. No. 15422

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS Mills</u>		c. LENGTH OF STAY IN 1b <u>JUNE 22, 1945</u> EASTON 2040.2	
4. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING SCHOOL</u>		d. STREET ADDRESS <u>115 SOUTH LANE</u>	
3. NAME OF DECEASED (Type or print) First <u>CLAYS</u> Middle <u>-</u> Last <u>DILLON</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 22, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>JAMES DILLON</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN HARMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
		INFORMANT Address <u>ROSEWOOD RECORDS</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>745X</u> <u>Bronchopneumonia - Hemorrhagic type</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Severe Kypho-scoliosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1-week</u> <u>Birth</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malformation of the cerebral hemispheres. - Prenatal.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/20/60, 1960, to 5/23/60, 1960, that I last saw the deceased alive on MAY 21, 1960, and that death occurred at 1:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Harry G. Butler</u>	M.D. <u>Rosewood Training School</u>	DATE SIGNED <u>5/23/60</u>
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u> <u>Owings Mills, Maryland</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. ELINE & Sons</u>		ADDRESS <u>Reisterstown Md.</u>	24a. REC'D BY REGISTRAR <u>MAY 27 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

CERTIFICATE OF DEATH

2408

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of birth: Jan 15, 1880

5. Place of birth: New York City

6. Date of death: Dec 10, 1925

7. Place of death: Home

8. Cause of death: Heart Disease

9. Signature of physician: Dr. J. Smith

10. Signature of registrar: John Doe

5450

CERTIFICATE OF DEATH

Reg. 05423

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION STELLA MARIS HOSPICE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 808 Mt. Holly St. 301.4	
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE DIPPOLD		d. STREET ADDRESS TOWSON RD. Baltimore	
4. DATE OF DEATH Month Day Year MAY 7 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARTIN DIPPOLD		14. MOTHER'S MAIDEN NAME MARGARET FLEISCHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 9	
17. INFORMANT Mrs. Mary Gehlert - North Shore Bx		Address North Shore Bx	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331X DUE TO (c) 331X			INTERVAL BETWEEN ONSET AND DEATH 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 19 59 to May 7, 1960 , that I last saw the deceased alive on May 7, 1960 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F O'Donnell M.D.		ADDRESS (Street, city or town, state) 2501 York Rd DATE/SIGNED 5/7/60	
PHYSICIAN'S NAME (Type) Charles F O'Donnell MD		Tolson 4 MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-11-60	22b. DATE THEREOF 5-11-60	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) BAITO Md
23. FUNERAL DIRECTOR'S SIGNATURE Leonard & Luck ADDRESS 5305 Hayford		24a. REC'D BY REGISTRAR DATE MAY 10 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hanes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5451

05424

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Ann County		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 76 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS --		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle --- Last DODD			4. DATE OF DEATH Month May Day 6 Year 19 60		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 7, 1909		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		12. KIND OF BUSINESS OR INDUSTRY Building		13. BIRTHPLACE (State or foreign country) Grasonville, Maryland	
14. CITIZEN OF WHAT COUNTRY? U. S. A.		15. FATHER'S NAME Alexander Dodd		16. MOTHER'S MAIDEN NAME Bessie Waters	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		18. SOCIAL SECURITY NO. 218-12-1364		19. INFORMANT Clin. Rec., Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 162.1 DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation: Aspiration of right ventricle of cranium. 3/24/60 (revealed metastatic brain anaplastic carcinoma of)					
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
23a. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 ---		23b. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
23d. (City or town) ---		23e. (County) ---		23f. (State) ---	
24. I certify that (I) (this hospital) attended the deceased from February 20, 19 60 to May 6, 19 60 , that (I) (we) last saw the deceased alive on May 6, 19 60 , and that death occurred at 3:45 AM , from the causes and on the date stated above.					
25a. SIGNATURE THOMAS R. HOOD, M.D.					
25b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 25c. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION					
26a. BURIAL, CREMATION, REMOVAL (Specify) Burial		26b. DATE THEREOF MAY 9		26c. NAME OF CEMETERY OR CREMATORY Chesterfield	
26d. LOCATION (City, town, or county) Centerville, Maryland		26e. (State) ---		26f. REC'D BY REGISTRAR ---	
26g. REGISTRAR'S SIGNATURE Arthur S. Kraus		26h. DATE MAY 12 '60		26i. REGISTRAR'S SIGNATURE ---	

Edgar Lane

Church Hill, Md.

CERTIFICATE OF DEATH

5251

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

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12. Signature of informant: [illegible]
13. Date of completion: [illegible]
14. Registrar's name: [illegible]
15. Registrar's title: [illegible]
16. Registrar's address: [illegible]
17. Registrar's telephone: [illegible]
18. Registrar's fax: [illegible]
19. Registrar's email: [illegible]
20. Registrar's website: [illegible]

5452

CERTIFICATE OF DEATH

05425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION <u>3306 Withloughby Rd</u>				d. STREET ADDRESS <u>3306 Withloughby</u>			
3. NAME OF DECEASED (Type or print) <u>Augusta M. Dreifus</u> First Middle Last				4. DATE OF DEATH <u>May 29</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Phillip Michael</u>				14. MOTHER'S MAIDEN NAME <u>Louise Depp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>11</u>		17. INFORMANT <u>William Mitchell-M.D.</u> Address <u>1015 Poplar Grove St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO <u>Arterio sclerotic type heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>with Congestive failure</u> (b) <u>Generalized arterio sclerosis</u> (c) <u>several years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis of flexor muscles of left foot due to cerebral hemorrhage 3 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>December 1, 1959</u> to <u>May 29, 1960</u> , that I last saw the deceased alive on <u>May 26, 1960</u> , and that death occurred at <u>12 Noon</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Mitchell M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>1015 Poplar Grove St Baltimore Md</u>			
DATE SIGNED <u>md</u>							
PHYSICIAN'S NAME (Type) <u>WILLIAM MITCHELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>6/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Sheppard</u> ADDRESS <u>-1300 Euterpe Pl.</u>				24a. REC'D BY REGISTRAR <u>JUN 2 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5453

CERTIFICATE OF DEATH

05426
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesaco Park</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Chesaco Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7935 Elmhurst Ave.</u>				d. STREET ADDRESS <u>1 7935 Elmhurst Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mr. John</u> Middle <u>H.</u> Last <u>Dungan, Sr.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-1906</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John H. Dungan</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212091401</u>		INFORMANT <u>Evelyn L. Dungan</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/17</u> , 19 <u>60</u> , to <u>5-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/17</u> , 19 <u>60</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>		DATE SIGNED <u>5/18/60</u>	
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Calvin S. Huns</u>			

(M)

(1)

2453

CERTIFICATE OF DEATH

10138

735 Cambridge St.

735 Cambridge St.

John H. Dunbar

John H. Dunbar

2-1-1-00

2-1-1-00

Harriet Thompson

John H. Dunbar

John H. Dunbar

2101/101

John H. Dunbar

2101/101

2-1-1-00

2-1-1-00

2-1-1-00

2-1-1-00

2-1-1-00

2-1-1-00

2-1-1-00

2-1-1-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5391

CERTIFICATE OF DEATH

Reg. Dist. No. 05427

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk (22)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2618 Yorkway				d. STREET ADDRESS 2618 Yorkway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SARAH Middle ANN Last DURRY				4. DATE OF DEATH Month May Day 17th Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scotland	
13. FATHER'S NAME Charles A. James				14. MOTHER'S MAIDEN NAME Sarah Hirst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mary Amann Address same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arterio-sclerotic heart disease with 34 years (c) anasarca Parasitic infestation of the liver 3-9 months							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-12 , 19 60 , to 5-17 , 19 60 , that I last saw the deceased alive on 5-17 , 19 60 , and that death occurred at 1:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Monnington Road DATE SIGNED 5/17/60 ACTUAL SIGNATURE Eugene F. Nevy M.D. Baltimore 22, Maryland PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley				ADDRESS Dundalk 22		24a. REC'D BY REGISTRAR DATE MAY 20 '60	
						24b. REGISTRAR'S SIGNATURE Anthony S. K...	

CERTIFICATE OF DEATH

2301

11-15-52

NAME OF DECEASED JAMES A. JONES		SEX Male		AGE 35		DATE OF BIRTH 11-15-17	
RACE White		MARRIAGE Married		EDUCATION High School		OCCUPATION Salesman	
PLACE OF BIRTH Baltimore, Md.		PLACE OF DEATH Baltimore, Md.		DATE OF DEATH 11-15-52		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 2301		REGISTRATION NO. 11-15-52	
SIGNATURE OF PHYSICIAN J. A. Jones		SIGNATURE OF REGISTRAR J. A. Jones		SIGNATURE OF DECEASED J. A. Jones		SIGNATURE OF WITNESS J. A. Jones	
ADDRESS OF DECEASED 1234 Main St.		ADDRESS OF REGISTRAR 1234 Main St.		ADDRESS OF DECEASED 1234 Main St.		ADDRESS OF WITNESS 1234 Main St.	
CITY OF DECEASED Baltimore		CITY OF REGISTRAR Baltimore		CITY OF DECEASED Baltimore		CITY OF WITNESS Baltimore	
STATE OF DECEASED Maryland		STATE OF REGISTRAR Maryland		STATE OF DECEASED Maryland		STATE OF WITNESS Maryland	
COUNTY OF DECEASED Baltimore		COUNTY OF REGISTRAR Baltimore		COUNTY OF DECEASED Baltimore		COUNTY OF WITNESS Baltimore	



11-15-52

MD STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5404

CERTIFICATE OF DEATH

05429
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY		c. LENGTH OF STAY IN 1b 14 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9626 ALDA Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JUNIUS H. DUVAL		4. DATE OF DEATH MAY 19 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Master		10b. KIND OF BUSINESS OR INDUSTRY McTRAINING School	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Duval		14. MOTHER'S MAIDEN NAME SALLY HART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 015-03-2506	
17. INFORMANT JENNIE DUVAL		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary occlusion DUE TO Chronic arteriosclerotic cardiovascular disease 20 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic arteriosclerotic cardiovascular disease 20 yrs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic congestive heart failure			INTERVAL BETWEEN ONSET AND DEATH Immediate
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1951 , to May 19, 1960 , that I last saw the deceased alive on May 19, 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kellie's March		ADDRESS (Street, city or town, state) 8100 HARFORD RD BALTO MD	
PHYSICIAN'S NAME (Type) Chas. F. Evans & Son		DATE SIGNED 5/21/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF May 23, 1960	22c. NAME OF CEMETERY OR CREMATORY ST. ANNA'S	22d. LOCATION (City, town, or county) (State) MOORESBORO NJ
23. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Evans & Son		24a. REC'D BY REGISTRAR May 23 '60	
ADDRESS 8802 HARFORD RD		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5454
CERTIFICATE OF DEATH

05428

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Halethorpe</u>			
c. LENGTH OF STAY IN 1b <u>8 yrs.</u>				d. STREET ADDRESS <u>1725 Winans Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1725 Winans Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elmer U. Duvall</u>				4. DATE OF DEATH <u>May 5 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16, 1887</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Enam.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Ella Kline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-9374</u>		17. INFORMANT <u>Lillie C. Duvall</u> Address <u>1725 Winans Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Arterio Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1957</u> to <u>5/6 1960</u> , that (I) (we) last saw the deceased alive on <u>5/6 1960</u> , and that death occurred at <u>2:22</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>James N. Frederick M.D.</u>				22b. DATE SIGNED <u>5/7/60</u>		22c. PHYSICIAN'S NAME (Type) <u>James N. Frederick M.D.</u>	
22d. ADDRESS <u>1305 Francis Ave, Balto. 27 Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose Inc. 1321 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR <u>MAY 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5455

CERTIFICATE OF DEATH

05430
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508 Windsor Mill Road		d. STREET ADDRESS 5508 Windsor Mill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MATILDA Middle E. Last DUVALL		4. DATE OF DEATH Month May Day 16 Year 1960	
5. SEX Fe Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Anne Arundel Co., Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Arnold		14. MOTHER'S MAIDEN NAME Eugenia Meubern	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT J. Brooke Duvall, Jr., 300 Gates Road Rd. - 4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) - Partial Intestinal loop Obstruction DUE TO 570.5 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) (2) - Arterio-sclerotic Heart Disease DUE TO 5 yrs. (c) (3) - Peritonitis Acute DUE TO 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - Protrusion of Vagina & Rectum			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March - 6 1959 to May 16 - 1960 , that I last saw the deceased alive on May 15 - 1960 , and that death occurred at 5 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts. - Baltimore - Md. - 57660	
DATE SIGNED May 17, 1960			
PHYSICIAN'S NAME (Type) Earl L. Chambers -		ADDRESS 4108 Liberty Hts. Ave. - Baltimore - Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/1960	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR MAY 17 '60	
ADDRESS Ellsworth Armacost-4600 Liberty Hgts. Ave.		24b. REGISTRAR'S SIGNATURE Charles S. Kenna	

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0250

VS. A15ME
5M 7/59

05431

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		d. STREET ADDRESS Box 416, Rt. 1, Sunshine Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 416, Rt. 1, Sunshine Avenue		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE P. EBBERTS		4. DATE OF DEATH Month Day Year May 1, 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-12-95	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Ebberts	
14. MOTHER'S MAIDEN NAME Clara Kaupp		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Frederick E. Hilmer. 721 N. Woodington Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery.		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR ADDRESS Wm. Cook Blight Inc. 6009 Harford Rd. (14)		24a. REC'D BY REGISTRAR DATE MAY 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 5/2/60	

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RECEIVED OF THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES
ON BEHALF OF THE NATIONAL INSTITUTE OF
ALLERGY AND INFECTIOUS DISEASES
FOR THE NATIONAL INSTITUTE OF
ALLERGY AND INFECTIOUS DISEASES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5392

CERTIFICATE OF DEATH

05432

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 222 Riverview Ave.		d. STREET ADDRESS 222 Riverview Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle Eberius Last 		4. DATE OF DEATH Month May Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Seipp		14. MOTHER'S MAIDEN NAME Dont Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 	
17. INFORMANT Royal Eberius 220 Riverview Ave.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-U Disease 422.1 DUE TO Symptoms Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) As above		INTERVAL BETWEEN ONSET AND DEATH 15 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) As above	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 5, 1960		20f. (City or town) May 7, 1960 (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1960 to May 7, 1960 , that (I) (we) last saw the deceased alive on May 5, 1960 , and that death occurred at 2 PM , from the causes and on the date stated above.			
22a. SIGNATURE M. B. Davis M.D.		22b. DATE SIGNED 5/11/60	
22c. PHYSICIAN'S NAME (Type) M. B. Davis M.D.		22d. ADDRESS 6800 Moravia Rd - Dundalk Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/60	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION (City, town, or county) (State) Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR DATE MAY 13 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Haines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5457

CERTIFICATE OF DEATH

05433

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (CATONSVILLE)</u>		c. LENGTH OF STAY IN 1b <u>7 WEEKS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHADY NOOK NURSING HOME</u>		d. STREET ADDRESS <u>2560 WILKENS AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DOROTHY</u> Middle <u>DAUGHERTY</u> Last <u>ENGELHARDT</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 14, 1887</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
13. FATHER'S NAME <u>GEORGE ESHBACH</u>		14. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>215-10-2162D</u> <u>217-03-4184A</u>	
17. INFORMANT <u>HARRY DAUGHERTY</u>		Address <u>3816 CEDAR DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Cardio-Vasc. Dis.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>60</u> , to <u>May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>60</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel Bakal</u>		DATE SIGNED <u>5/15/60</u>	
PHYSICIAN'S NAME (Type) <u>DANIEL BAKAL</u>		ADDRESS (Street, city or town, state) <u>3600 Lochman Dr</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUNDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE L. SCHWAB</u> <u>Francis H. Miller</u>		24a. REC'D BY REGISTRAR <u>MAY 18 '60</u>	
ADDRESS <u>2101 Indebank Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1850

CERTIFICATE OF DEATH

1850



[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5458

05434

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE (Garrison)				c. LENGTH OF STAY IN 1b YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxrich Nursing Home				d. STREET ADDRESS 6 Reservoir Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Maurice First Franklin Middle Ensor Sr. Last		4. DATE OF DEATH May 31 1960		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 7th 1897		9. AGE (In years last birthday) 62 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George F. Ensor				14. MOTHER'S MAIDEN NAME Alice Rosier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 214-01-5730		17. INFORMANT Mrs. Julia Z. Ensor - 6 Reservoir Rd. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CANCER of feet 950.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL VASCULAR ACCIDENT							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from November 1958 to MAY 1960, that (I) (we) last saw the deceased alive on 5-10-1960 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Francis T. Daly				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) FRANCIS T DALY	
22d. ADDRESS 1725 REISTERTOWN Rd, Pikesville Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/60		23c. NAME OF CEMETERY OR CREMATORY Dried Ridge Cem.		23d. LOCATION (City, town, or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Clay J. Tiekner & Sons - Baltore Md				25a. REC'D BY REGISTRAR JUN 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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RECORDS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5459

CERTIFICATE OF DEATH

05435

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERLEA		c. LENGTH OF STAY IN 1b 30YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6801 BELAIR ROAD #6.		d. STREET ADDRESS 6801 BELAIR ROAD #6	
3. NAME OF DECEASED (Type or print) First ESTELLA Middle MAE Last FATZINGER		4. DATE OF DEATH Month MAY Day 24 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 18, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD BECK		14. MOTHER'S MAIDEN NAME NETTIE EBERTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-26-5916	
INFORMANT RUSSELL C. FATZINGER		Address 4218 CARDWELL AVE #6.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 420-1 DUE TO hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO diabetes (b) NOTE: deceased a med. examiner (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from oct 1953 , to 22 May 60 , that I last saw the deceased alive on May 22 , 19 60 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. may 23-60. ADDRESS (Street, city or town, state) 1 W. OVERLEA AVE DATE SIGNED ACTUAL SIGNATURE Richard Rigler M.D. PHYSICIAN'S NAME (Type) RICHARD RIGLER BALTO. 6 Mo			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION MAY 28, 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEM.		22d. LOCATION (City, town, or county) (State) BALTO CITY MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE LASSMAN Funeral Home 7401 Belair Road #6.		24a. REC'D BY REGISTRAR MAY 31 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8. *Journal of the American Medical Association*, 1990; 263: 1033-1036.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 14 Film G262 5/12/60 1wk

CERTIFICATE OF DEATH

05436

Reg. Dist. No.

5460

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>3V01.4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>				d. STREET ADDRESS <u>7562 Cottage Ave</u>			
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First Middle Last <u>FELDMAN</u>				4. DATE OF DEATH Month <u>5-</u> Day <u>7-</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Goldman</u>				14. MOTHER'S MAIDEN NAME <u>Freda unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Samuel Weissman - same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3h.</u> <u>10yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-19-</u> , 19 <u>60</u> , to <u>5-7-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-7-</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Wilmer K. Gallagher</u> M.D. <u>6209 Frederick Ave.</u> <u>5-7-60</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher M.D.</u> <u>Baltimore-28, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>5-7-60</u>		<u>New York</u>		<u>N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc 2100 Eutaw Place</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5461

CERTIFICATE OF DEATH

05437
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>				c. LENGTH OF STAY IN 1b <u>7 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sunshine Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Amos</u> Middle <u>Fitch</u> Last				4. DATE OF DEATH <u>May</u> Month <u>12</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 27 1887</u>	
9. AGE (In years, last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm.</u>		11. BIRTHPLACE (State or foreign country) <u>Fullerton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John B. Fitch</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lippel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-18-0888</u>		17. INFORMANT <u>Mary Elene Fitch</u> Address <u>Kingsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Atherosclerosis</u> 334X DUE TO <u>with Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Mar 4</u> , 19 <u>60</u> , to <u>May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				DATE SIGNED <u>5-12-60</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM A. TYSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/14/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Garrettsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Rutz</u>				ADDRESS <u>Garrettsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

05438
Reg. Dist. No.

5462

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7 mth 21 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle John Last Foley		4. DATE OF DEATH Month MAY Day 28 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1889
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown T. J. Foley		14. MOTHER'S MAIDEN NAME Ellen Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown No		16. SOCIAL SECURITY NO. 159-10-6862	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1959 to May 28, 1960 that I lost saw the deceased alive on May 27, 1960 , and that death occurred at 1:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward T. Schuur		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-31-60	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUN 1 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Haines	

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH

CERTIFICATE OF DEATH

2585

(1902)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5463

Items 3,8,& 9 Film G262 5/12/60 iwk

CERTIFICATE OF DEATH

05439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellerslie Farm		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearl Middle Ann Last Ford		4. DATE OF DEATH Month May Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884
9. AGE (In years last birthday) 72 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Ahern		14. MOTHER'S MAIDEN NAME Clorinda West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. John Brice, 424 Rosebank Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Disease (c) Arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hr. 5 yrs. 5 yrs.?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11:24 , 1955 , to 1960 , that I last saw the deceased alive on 5-2 , 1960 , and that death occurred at 4 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Urban		ADDRESS (Street, city or town, state) 805 Frederick Ave 28 Md	
PHYSICIAN'S NAME (Type) George E. URBAN		DATE SIGNED 5-7-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-7-60	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's P.E. Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAY 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

5483

CERTIFICATE OF DEATH

5483

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1900		BALTIMORE		MD		USA		USA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
W		W		M		M		H		H		H		H	
MOTHER		FATHER		MOTHER		FATHER		MOTHER		FATHER		MOTHER		FATHER	
JANE HARRIS		JOHN HARRIS		JANE HARRIS		JOHN HARRIS		JANE HARRIS		JOHN HARRIS		JANE HARRIS		JOHN HARRIS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
JAN 15 1945		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE		NO	
DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAN 17 1945		BALTIMORE		BALTIMORE		MD		USA		BALTIMORE		MD		USA	
NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY		NAME OF INTERVIEWER		NAME OF WITNESS		NAME OF SIGNER		NAME OF SIGNER	
JAMES H. HARRIS		JOHN HARRIS		JANE HARRIS		JOHN HARRIS		JANE HARRIS		JOHN HARRIS		JANE HARRIS		JOHN HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5464

CERTIFICATE OF DEATH

05440

Item 9 Film 8262 5/11/60 iwk

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 18 YEARS-7 MO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle P Last FRANKLIN		4. DATE OF DEATH Month MAY Day 5 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 1, 1975
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JOSEPH CLEMSON		14. MOTHER'S MAIDEN NAME MARY AULD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank R. Smith Jr.		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cornary Arterio - Sclerosis (c) Arterio Sclerotic Cardio Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 18 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-20 1960 , to 5-5 1960 , that (I) (we) last saw the deceased alive on 5-5 1960 , and that death occurred at 8:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 5/5/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-9-60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR MAY 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

0426

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 330 Greenlow Rd.					d. STREET ADDRESS 330 Greenlow Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Garnett					4. DATE OF DEATH Month May Day 21 Year 1960				
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1882		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles F. Graves					14. MOTHER'S MAIDEN NAME Katherine				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1					16. SOCIAL SECURITY NO. 1		17. INFORMANT Address Miss Pat Garnett, 330 Greenlow Rd. #28		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1960 to May 21, 1960 , that (I) (we) last saw the deceased alive on May 18, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE George A. Knipp					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 23, 1960		
22c. PHYSICIAN'S NAME (Type) George A. Knipp, M. D.					22d. ADDRESS 4116 Edmondson Avenue				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 24/60		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cent.		23d. LOCATION (City, town, or county) (State) Balto. Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave.					ADDRESS 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE MAY 24 '60		25b. REGISTRAR'S SIGNATURE Witzke

2462

CENTRAL OF DATA

051411

Baltimore

Baltimore

10 yrs

10 yrs

350 Greenlow Rd.

450 Greenlow Rd.

May

Elizabeth Garrett

May

May 4, 1982

78

E.E.

G.H.

MR.

USA

Charles F. Graves

Katherine

Nice Pat Garrett, 350 Greenlow Rd. 450



Bureau May 24/80 101 Elmwood Ave.
Baltimore, Md.

Bureau, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5466

CERTIFICATE OF DEATH

05442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN TB 7 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Conv. Home		d. STREET ADDRESS 328 S. Clinton St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sigmund Gedrowicz		4. DATE OF DEATH Month May Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp.	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Julia Gedrowicz		Address 328 S. Clinton St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Malaria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized a SCV Diene (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 4/10/60 , 19 60 , to 5/5/60 , 19 60 , that I last saw the deceased alive on 5/5/60 , and that death occurred at 1 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 679 W. Washington Blvd. Baltimore 30 DATE SIGNED 5/6/60 ACTUAL SIGNATURE Joseph G. Lawkaitis M.D. PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS MD 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5-7-1960 22c. NAME OF CEMETERY OR CREMATORY Holy Rosary 22d. LOCATION (City, town, or county) (State) German Hill Rd. Md. 23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda ADDRESS 2829 Hudson St. 24, Md. 24a. REC'D BY REGISTRAR MAY 10 '60 24b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2022

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>10/15/1977</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Maryland</i></p>		<p>6. RACE <i>White</i></p>	
<p>7. OCCUPATION <i>Software Engineer</i></p>		<p>8. MARITAL STATUS <i>Married</i></p>	
<p>9. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>10. MANNER OF DEATH <i>Natural</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>Dr. Jane Smith</i></p>			
<p>12. SIGNATURE OF REGISTRAR <i>John Doe</i></p>			
<p>13. DATE OF DEATH <i>10/20/2022</i></p>			
<p>14. PLACE OF DEATH <i>Home</i></p>			
<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>			
<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>			
<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>			
<p>18. SIGNATURE OF WITNESS <i>John Doe</i></p>			
<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>			
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<p>99. SIGNATURE OF WITNESS <i>John Doe</i></p>			
<p>100. SIGNATURE OF WITNESS <i>John Doe</i></p>			

THE STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18
 This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State of Maryland.
 WITNESSED my hand and the seal of the Department of Health at Baltimore, Maryland, this 10th day of November, 2022.
 REGISTRAR OF DEATHS
 JOHN DOE

5467

CERTIFICATE OF DEATH

05443

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 39yr24days		d. STREET ADDRESS 1722 Linden Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lizzie (Elizabeth) Gentile		4. DATE OF DEATH Month Day Year May 10 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY housework	11. BIRTHPLACE (State or foreign country) Rumania
12. CITIZEN OF WHAT COUNTRY? Rumania		13. FATHER'S NAME ? Syncoski	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 19 53 , to May 10, 19 60 , that I last saw the deceased alive on May 10, 19 60 , and that death occurred at 9:35a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas M.D.		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-19-60	
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried 5/20/60 at Catholic		22b. DATE THEREOF 5/20/60	
22c. NAME OF CEMETERY OR CREMATORY 4300 Old Federal		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Fahay		ADDRESS 1318 Light	
24a. REC'D BY REGISTRAR MAY 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5468

CERTIFICATE OF DEATH

Reg. Dist. No. 05444

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 03 New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton, Rural				c. LENGTH OF STAY IN lb 2 1/4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Carmel Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John T. Glaccum, Sr.				4. DATE OF DEATH Month Day Year 5-4-60 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-1885	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l manager				10b. KIND OF BUSINESS OR INDUSTRY glove mfg.		11. BIRTHPLACE (State or foreign country) New Jersey	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Glaccum				14. MOTHER'S MAIDEN NAME Julia ?????? Mooney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. INFORMANT Address Mrs. John T. Glaccum Jr., above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerosis - generalized 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 59 , to May , 19 60 , that I last saw the deceased alive on May 3 , 19 60 , and that death occurred at 3 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. Herbert Mueller Jr. M.D. York Rd. Parkton, P.O. 5/4/60							
ACTUAL SIGNATURE C. HERBERT MUELLER Jr. PHYSICIAN'S NAME (Type) PARKTON, P.O.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-60		22c. NAME OF CEMETERY OR CREMATORY Holy Name Cemetery		22d. LOCATION (City, town, or county) (State) Jersey City, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR MAY 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

Brooks Funeral Service, Towson, Md.

Funeral 2-2-60

Holy Name Co. - Jersey

Jersey City, New Jersey

HEARST

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5401 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06605**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2015 Hammond Ferry Rd</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lansdowne</u> d. STREET ADDRESS <u>2015 Hammond Ferry Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie Sabina</u> Middle <u>GLASER</u> Last 4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1960</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 17, 1881</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (State or foreign country) <u>England</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>J. Smith</u> 14. MOTHER'S M maiden NAME <u>Ann unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>ALFRED CONNOR</u> Address <u>2709 Hemlock Ave.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio vascular heart disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D. EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-4-60</u> 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 31, 1960</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>JUN 6 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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5469

CERTIFICATE OF DEATH

Reg. No. 05445

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5yr 4mths ldy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Gogin Last Gogin				4. DATE OF DEATH Month May Day 12 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 24, 1891	
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chief engineer				10b. KIND OF BUSINESS OR INDUSTRY Merchant Marines			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 1913 and 1944			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Generalized carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Prostate carcinoma DUE TO (c) Prostate carcinoma							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 24, 1958 , to May 12, 1960 , that I last saw the deceased alive on May 12, 1960 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. P.M. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-13-60							
ACTUAL SIGNATURE Anthony S. Garafano				PHYSICIAN'S NAME (Type) Anthony S. Garafano, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 5-16-60			
22c. NAME OF CEMETERY OR CREMATORY Greenmount				22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H.w.Jenkins & Sons Co.				24a. REC'D BY REGISTRAR DATE MAY 16 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Harris							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2588

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DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5470 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balt.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Int. Wilson</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville 28</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Int. Wilson State Hosp.</u>				d. STREET ADDRESS <u>1927. Attavine Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle <u>ANTHONY</u> Last <u>GONCE</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-29-1910</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linotype operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>W.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. Gonce</u>				14. MOTHER'S MAIDEN NAME <u>Caroline E. Gonce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-07-3935</u>		17. INFORMANT Address <u>Int. Wilson Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound thru head.</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>mental Depression</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Tuberculosis 14 yrs. Depression 016X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>1 yr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>7:10 p.m. May 21 1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work <u>Hosp.</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hosp.</u>		20f. (City or town) (County) (State) <u>Int. Wilson Balto. Md.</u>	
21. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D.D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D.D. GAPLES</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Hume</u>				ADDRESS <u>Pike & Mt.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		RELIGION	
1000 ...		...		...		...		...		...
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
4/4/68		...		...		...		...		...
SIGNATURE OF EXAMINER		TITLE		SIGNATURE OF WITNESS		TITLE		SIGNATURE OF CORONER		TITLE	
...		



FILED IN ...
 APR 5 1968
 BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled (in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5471

CERTIFICATE OF DEATH

05447
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock		c. LENGTH OF STAY IN 1b 75 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Court Road				d. STREET ADDRESS Old Court Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evaristo A. Graziani		First Middle Last		4. DATE OF DEATH 5 22 19 60		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> Never married Divorced		8. DATE OF BIRTH March 9, 1870	
9. AGE (In years last birthday) 90		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Anthony Graziani		14. MOTHER'S MAIDEN NAME Flavia ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) *****		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Catherine M. Graziani	
Address Woodstock, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis - 420.1 DUE TO Generalized severe arteriosclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. severe peripheral vascular disease - DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 20 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from MAY 1, 1958 , to MAY 22, 1960 , that I last saw the deceased alive on MAY 22, 1960 , and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas E. Wheeler		M.D. 3601 Clifmar Road, Balto. 7, Md.		PHYSICIAN'S NAME (Type) Dr. Thomas E. Wheeler		3601 Clifmar Road, Balto. 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/60		22c. NAME OF CEMETERY OR CREMATORY St. Alphonsus Cemetery		22d. LOCATION (City, town, or county) (State) Woodstock, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Road		24a. REC'D BY REGISTRAR MAY 31 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE	

402

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818 2

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5472

CERTIFICATE OF DEATH

05448

1. PLACE OF DEATH a. COUNTY Baltimore				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 Hours				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital								d. STREET ADDRESS 1317 Ensor Street (2)								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH				Middle ---				Last GREEN, JR.				4. DATE OF DEATH Month May				Day 10				Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1924				9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months 35		IF UNDER 24 HRS. Days 35		Hours 35		Min. 35					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME Joseph Green, Sr								14. MOTHER'S MAIDEN NAME Emma Jones															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II 217-16-5038				17. INFORMANT Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) JAUNDICE (c) CIRRHOSIS OF LIVER																INTERVAL BETWEEN ONSET AND DEATH 4 DAYS UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11:40 AM 5/10/60 to 5:40 PM 5/10/60 that (I) (we) last saw the deceased alive on May 10 19 60 , and that death occurred at P M, from the causes and on the date stated above.																							
22a. SIGNATURE John D. Talbert, M.D.								M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5/11/60											
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.								22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-16-60				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town, or county) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders								ADDRESS 217 E. Preston St. Baltimore, Md.				25a. REC'D BY REGISTRAR DATE MAY 17 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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U.S. DEPT. OF JUSTICE

5473

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

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VR A1S (4)
ISM 9/59

5474

05450

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 1-1/2 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 17 WALDRON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM J HANNIGAN			4. DATE OF DEATH Month Day Year MAY 15 19 60				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 16, 1898	
				9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY BALTO CO. TRANS. & RECORD DEPT		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MICHAEL J HANNIGAN				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME JULIA BURNS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11 215-01-2005		17. INFORMANT CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CARCINOMA OF LARYNX DUE TO (c) 1 YEAR						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that A (this hospital) attended the deceased from 12:20 A.M. to 1:50 A.M. May 15, 1960 to May 15, 1960 , that X (we) last saw the deceased alive on May 15, 1960 , and that death occurred at 1:50 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Clovis M. Snyder				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-15-60	
22c. PHYSICIAN'S NAME (Type) CLOVIS M. SNYDER				22d. ADDRESS M.D. VAH BALTIMORE MD * FT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-18-60		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE FRANK H NEWELL INC				25. RECORD BY REGISTRAR MAY 28 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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CHARTER AIR CO. OF DENVER

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HANDLING

DATE

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BY MAIL

BY AIR

TO

FROM

MR. J. M. LEE

MR. J. M. LEE

MAINTENANCE

REPAIRS

WARRANTY

WARRANTY

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REPAIRS

WARRANTY



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Charles J. Lee

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1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1908 Tyler Road				d. STREET ADDRESS 1908 Tyler Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret I. Hardesty		First Margaret I. Hardesty		Middle 		Last 	
4. DATE OF DEATH May 4, 1960		Month May		Day 4		Year 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 		IF UNDER 24 HRS. Days 		Hours 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Powers				14. MOTHER'S MAIDEN NAME Mary Souberon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. M. Himmelman Address 1908 Tyler Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Art. Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 5 years 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 1-15-55 to 5-4-60 that (I) (we) last saw the deceased alive on 5-3-60 , and that death occurred at 3A M. from the causes and on the date stated above.							
22a. SIGNATURE Jack C Collins				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-6-60	
22c. PHYSICIAN'S NAME (Type) JACK C COLLINS				22d. ADDRESS 2 Kinship Balt. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/7/60		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				25a. REC'D BY REGISTRAR DATE MAY 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

10000

CENTRAL BANK OF GREAT

2303



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the document. Some words like "CENTRAL BANK" and "GREAT" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5475
CERTIFICATE OF DEATH
05452

1. PLACE OF DEATH a. CITY OR COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN lb 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1433 East Lombard Street, (31) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD ----- HARRIS				4. DATE OF DEATH Month Day Year May 26 1960															
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 2, 1888		9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Walter				10b. KIND OF BUSINESS OR INDUSTRY Hotel				11. BIRTHPLACE (State or foreign country) Annapolis, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME West Harris				14. MOTHER'S MAIDEN NAME Ella Austin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I 217-01-4573				17. INFORMANT Clinical Records VA Hospital, Baltimore 18, Md. Fort Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EPIDERMOID CARCINOMA, SOFT PALATE 1444 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA, RIGHT LOWER LOBE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS 5 DAYS										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from May 19 1960, to May 26 1960, that (X) (we) last saw the deceased alive on May 26 1960, and that death occurred at P. M., from the causes and on the date stated above.																			
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.				22b. DATE 5/21/60				22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.				22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-1-1960				23c. NAME OF CEMETERY OR CREMATORY National Cemetery				23d. LOCATION (City, town, or county) (State) Baltimore Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese Mortuary, 108 Washington St. Annapolis, Md.				25a. REC'D BY REGISTRAR DATE MAY 31 '60				25b. REGISTRAR'S SIGNATURE C. L. S. Hines											

05132

DEPARTMENT OF HEALTH

2532

1. Name of patient: [illegible]
2. Date of birth: [illegible]
3. Sex: [illegible]
4. Race: [illegible]
5. Address: [illegible]
6. City: [illegible]
7. State: [illegible]
8. Zip: [illegible]
9. Date of admission: [illegible]
10. Date of discharge: [illegible]
11. Name of attending physician: [illegible]
12. Name of hospital: [illegible]
13. Name of clinic: [illegible]
14. Name of laboratory: [illegible]
15. Name of X-ray department: [illegible]
16. Name of pathology department: [illegible]
17. Name of radiology department: [illegible]
18. Name of surgery department: [illegible]
19. Name of medicine department: [illegible]
20. Name of pediatrics department: [illegible]
21. Name of obstetrics and gynecology department: [illegible]
22. Name of ophthalmology department: [illegible]
23. Name of otolaryngology department: [illegible]
24. Name of dermatology department: [illegible]
25. Name of neurology department: [illegible]
26. Name of psychiatry department: [illegible]
27. Name of orthopedics department: [illegible]
28. Name of urology department: [illegible]
29. Name of gastroenterology department: [illegible]
30. Name of cardiology department: [illegible]
31. Name of pulmonology department: [illegible]
32. Name of infectious diseases department: [illegible]
33. Name of immunology department: [illegible]
34. Name of allergy department: [illegible]
35. Name of endocrinology department: [illegible]
36. Name of nephrology department: [illegible]
37. Name of hematology department: [illegible]
38. Name of oncology department: [illegible]
39. Name of radiation oncology department: [illegible]
40. Name of surgical oncology department: [illegible]
41. Name of medical oncology department: [illegible]
42. Name of pediatric oncology department: [illegible]
43. Name of geriatrics department: [illegible]
44. Name of palliative care department: [illegible]
45. Name of hospice department: [illegible]
46. Name of rehabilitation department: [illegible]
47. Name of physical therapy department: [illegible]
48. Name of occupational therapy department: [illegible]
49. Name of speech therapy department: [illegible]
50. Name of nutrition department: [illegible]
51. Name of dietetics department: [illegible]
52. Name of pharmacy department: [illegible]
53. Name of medical records department: [illegible]
54. Name of billing department: [illegible]
55. Name of insurance department: [illegible]
56. Name of legal department: [illegible]
57. Name of ethics department: [illegible]
58. Name of quality improvement department: [illegible]
59. Name of patient education department: [illegible]
60. Name of community outreach department: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

5476

1. PLACE OF DEATH o. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY name	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2225 W Baltimore St 23 301.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 2225 W Baltimore St	
3. NAME OF DECEASED (Type or print) Wilbur Helwig		4. DATE OF DEATH Month May Day 2 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1999
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRIAL	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Helwig		14. MOTHER'S MAIDEN NAME Florence Rutter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 4-5-5835	
17. INFORMANT Personal History		Address Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 12 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 49 , to May 2 , 19 60 , that I last saw the deceased alive on May 2 , 19 60 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Milton B. Kress M.D. Eudowood Sanatorium, Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF 5-5-60			
22c. NAME OF CEMETERY OR CREMATORY WESTERN			
22d. LOCATION (City, town, or county) (State) BALTIMORE MD			
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Miller 2101 Frederick Ave			
24a. REC'D BY REGISTRAR DATE MAY 3 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kress			

39. 33

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05454

Reg. Dist. No.

5477

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2115 St. Lukes Lane</u>		d. STREET ADDRESS <u>2115 St. Lukes Lane</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>William E. Henritz</u>			4. DATE OF DEATH <u>May 30 1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1881</u>		
			9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13. FATHER'S NAME <u>George Henritz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Subock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT Address <u>Mrs. Elsie L. Henritz - 2115 St. Lukes Lane</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>*****</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>*****</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>*****</u> 19 p. <u>*****</u>	20d. INJURY OCCURRED <u>*****</u> While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>*****</u>	20f. (City or town) (County) (State) <u>*****</u>

21. I certify that I attended the deceased from <u>19 50</u> to <u>May</u> 19 <u>60</u> , that I last saw the deceased alive on <u>24 May</u> 19 <u>60</u> , and that death occurred at <u>1:10 A.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Millard T. Traband</u>	DATE SIGNED <u>5/31/60</u>
ADDRESS (Street, city or town, state) <u>5101 Gwynn Oak Avenue, Baltimore, 7, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE-THEREOF <u>June 1, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stensbury</u>		24a. REC'D BY REGISTRAR <u>June 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of birth: Jan 15, 1900
5. Place of birth: New York City
6. Usual residence: 123 Main St, Baltimore, Md
7. Date of death: Dec 10, 1945
8. Time of death: 10:30 AM
9. Place of death: Home
10. Cause of death: Heart Disease
11. Nature of disease: Coronary Artery Disease
12. Duration of disease: Several years
13. Date of onset: Unknown
14. Date of diagnosis: Unknown
15. Name of physician: Dr. J. Smith
16. Name of hospital: None
17. Name of funeral home: None
18. Name of undertaker: None
19. Name of cemetery: None
20. Name of burial place: None

21. Name of informant: John Doe
22. Address of informant: 123 Main St, Baltimore, Md
23. Signature of informant: [Signature]
24. Date of completion: Dec 10, 1945
25. Name of registrar: None
26. Address of registrar: None
27. Signature of registrar: None
28. Date of registration: None
29. Name of medical examiner: None
30. Address of medical examiner: None
31. Signature of medical examiner: None
32. Date of examination: None
33. Name of pathologist: None
34. Address of pathologist: None
35. Signature of pathologist: None
36. Date of examination: None
37. Name of coroner: None
38. Address of coroner: None
39. Signature of coroner: None
40. Date of examination: None

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of the certificate is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5478 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05455

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 19 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res. 810 E. Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
3. NAME OF DECEASED (Type or print) Waldo James Henry		4. DATE OF DEATH Month May Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1909
9. AGE (In years and birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Open Hearth-Office Wrk. Beth. Steel	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Henry		14. MOTHER'S MAIDEN NAME Maude Iman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-0995	
17. INFORMANT Mrs. Elizabeth Henry		Address 810 E St. 19, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot wound Thru' Right DUE TO Parietal Region Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot Self c. 38 cal Pistol	
20c. TIME OF INJURY Month, Day, Year 11/30 a.m. 5-5 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Sparrows Pt. (County) BALTO. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/5/60.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-1960	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR MAY 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5402

CERTIFICATE OF DEATH

05456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Relay Hill Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gladys Hill First Middle Last		4. DATE OF DEATH May Month 16 Day Year 60 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Gall Bladder with generalized metastatic lesions. DUE TO 155.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Two months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1960 , to May 16, 1960 , that I last saw the deceased alive on May 16, 1960 , and that death occurred at 5:30 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Lewis P. Gundry M.D.			
PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/19/60	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Amber 1328 Superior Loring Rd		24a. RECEIVED BY REGISTRAR MAY 18 1960 24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS. A15ME
5M 7/59

5479 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05457

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN lb 25 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cottage Ave.				d. STREET ADDRESS 2703 DeIK Ct.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isiah Middle L. Last Hill				4. DATE OF DEATH Month May Day 29 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-1932	
9. AGE (In years last birthday) 28 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		11. BIRTHPLACE (State or foreign country) Chester Co., S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Hill				14. MOTHER'S MAIDEN NAME Nancy Lichtner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Hill 2703 DeIK Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax bilaterally and hemopericardium 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stab wounds of chest and abdomen DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Stab wounds of chest and abdomen					
20c. TIME OF INJURY Hour XX p.m. Month, Day, Year May 29, 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Edgemere, Baltimore, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R S Fisher MD M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/30/60	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-3-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or country) (State) Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR Randolph J. Collick 1412 E. Preston St.				24a. REC'D BY REGISTRAR JUN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

2

THE STATE
DEPARTMENT



NO

Robert Hill

Robert Hill, 2225 Oak St.
Honey Hill, Tenn.

Health and Physically in good condition

Each wound of chest and abdomen

Also wounds of arm and leg

Robert Hill, 2225 Oak St.
Honey Hill, Tenn.

MARYLAND STATE DEPARTMENT OF HEALTH 5480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06618**

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wrights Mill Rd.				d. STREET ADDRESS Wrights Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HANS Middle HOESE Last HOESE				4. DATE OF DEATH Month May Day 22 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1887	
9. AGE (In years last birthday) 72 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Arch Designer - self employed				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Wilhelm				14. MOTHER'S MAIDEN NAME Barbara E. Weber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Harry M. Ashman - 1800 N. Charles St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease DUE TO (c)</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE GEO. S. M. KIEFFER M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/14/60		22c. NAME OF CEMETERY OR CREMATORY Louder Park Crem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Son - Baltore, Md.				24a. REC'D BY REGISTRAR JUN 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kimes	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF EXAMINER _____		DATE _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF CLERK _____	

RECEIVED
 APR 13 1907
 1037 WOOD ST.

5481

CERTIFICATE OF DEATH

05458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loreley</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loreley</u>	
3. NAME OF DECEASED (Type or print) <u>William J. Holter</u>		d. STREET ADDRESS <u>1 Allender Road,</u>	
4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1876</u>
9. AGE (In year lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>William H. Holter</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Weis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-14-9402</u>	
17. INFORMANT <u>Margaret C. Holter, Loreley, Maryland.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Acc. Ident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCD</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>60</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>5-3-6</u>	
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		PHYSICIAN'S NAME (Type) <u>William A. Tyson</u> <u>Kingsville Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May, 7, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's</u>		22d. LOCATION (City, town, or county) (State) <u>Bradshaw Balto., Md.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs</u>		ADDRESS <u>Abingdon Md.,</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1911

DATE OF DEATH

AGE

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY REGISTRAR

NAME OF DEPUTY CLERK

NAME OF DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY CLERK

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NAME OF DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

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NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5482 CERTIFICATE OF DEATH

05459

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY -		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 57 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 543 W. Lafayette Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle O. Last HOPES			4. DATE OF DEATH Month May Day 17 Year 1960		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1889		9. AGE (In years last birthday) yrs. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Entertainer		10b. KIND OF BUSINESS OR INDUSTRY Show Business		11. BIRTHPLACE (State or foreign country) Richmond, Virginia	
13. FATHER'S NAME William Hopes			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME Deanie Smith			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		
16. SOCIAL SECURITY NO. 214-40-1118			17. INFORMANT Address Division Clin. Rec., Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE AMPULLA OF VATER WITH 155.1 XXXXX METASTASES TO REGIONAL LYMPH NODES, LIVER AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) CACHEXIA					INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from March 21, 1960 to May 17, 1960 , that (I) (we) last saw the deceased alive on May 17, 1960 , and that death occurred at 4:30 P. M. from the causes and on the date stated above.					
22a. SIGNATURE John D. Talbert, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/19/60	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
23d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips			ADDRESS 1808 N. Monroe St. Balto. Md.		25a. REC'D BY REGISTRAR DATE MAY 20 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

1992

5483

CERTIFICATE OF DEATH

05460
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armacost Nursing Home</u>		d. STREET ADDRESS <u>1657 Woodbourne Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sylvia S. Howland</u>		4. DATE OF DEATH Month Day Year <u>May 16 19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Sedgwick</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte (Unknown last name)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>723 189312</u>	
INFORMANT <u>DeForest H. Howland</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN. 11, 1960</u> to <u>MAY 16, 1960</u> that I last saw the deceased alive on <u>MAY 15, 1960</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1532 HAVENWOOD RD</u> ACTUAL SIGNATURE <u>Arthur Korfgen</u> M.D. <u>BALTIMORE-18 MD</u> PHYSICIAN'S NAME (Type) <u>ARTHUR KORFGIN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>5/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO COUNTY</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '60</u>	
ADDRESS <u>5305 Harford Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2483

CERTIFICATE OF DEATH

05460

Deceased

1917

10-1-17

10-1-17

1917

Deceased

1917

1917

Deceased

Deceased

5484

CERTIFICATE OF DEATH

05461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>55</i> <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>102 Dumbarton Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mr. James</i> Middle <i>Thomas</i> Last <i>Hubbard</i>		4. DATE OF DEATH Month <i>May</i> Day <i>31st</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 27, 1885</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Advertising Rep.</i>	11. BIRTHPLACE (State or foreign country) <i>Suffolk, Virginia</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Advertising Rep.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lepron Hubbard</i>		14. MOTHER'S MAIDEN NAME <i>Laurette ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>216-32-6495 A.</i>	
17. INFORMANT <i>Mrs. Sue E. Hubbard, same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>aplastic Anemia</i> DUE TO (b) <i>Arteriosclerotic Cardio-vascular Disease</i> DUE TO (c) <i>Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>17 Aug.</i> , 19 <i>59</i> , to <i>31 May</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>31 May</i> , 19 <i>60</i> , and that death occurred at <i>2 P.</i> -M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William H. Kammer, Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>6011 York Rd. Balto.</i>	
PHYSICIAN'S NAME (Type) <i>William H. Kammer-Jr.</i>		DATE SIGNED <i>12/24/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>6/3/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>JUN 2 '60</i>	
ADDRESS <i>5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Huns</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3242

5403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4128 Wilkens Ave (Home)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA C HUDSON		4. DATE OF DEATH May 30, 1960	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1866
9. AGE (In years last birthday) 93		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Phillip Kohl		14. MOTHER'S MAIDEN NAME Elizabeth Weckesser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Louise Plassil, 4128 Wilkens Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Longestive Heart Failure. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/10 , 19 59 , to 5/30 , 19 60 , that I last saw the deceased alive on 5/30 , 19 60 , and that death occurred at 8:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1305 Francis Ave. Balto 27 Md DATE SIGNED 5/31/60 ACTUAL SIGNATURE Dr. J. Frederick M.D. PHYSICIAN'S NAME (Type) JN Frederick MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/60	
22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Druid Hill Pk. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE JUN 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2403

Baltimore

Address

Address

1128 Wilkens Ave (Home)

1128 Wilkens Ave

ANNA C RUTSON

MAY 30, 1900

Female White

Oct. 27, 1880

Housewife

Home

Maryland

Phillip Kohl

Elizabeth Beckeser

none

Louise Plazati, 1128 Wilkens Ave

Grave Hill Bk. Bldg. No.

St. Pauls Cemetery

Howard T. Hubbard 1128 Wilkens Ave.

CERTIFICATE OF DEATH

05463

Reg. Dist. No.

5485

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westchester Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEO Middle A Last HYNES				4. DATE OF DEATH Month May Day 25 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hynes				14. MOTHER'S MAIDEN NAME Mary Keiffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-1083		17. INFORMANT Address Mrs. E.E. Hynes, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 wks.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1 , 19 59 , to 5-25 , 19 60 , that I last saw the deceased alive on 5-25 , 19 60 , and that death occurred at 12:10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 46 Church Road Ellicott City, Md DATE SIGNED 5-26-60							
ACTUAL SIGNATURE Thomas F. Herbert M.D.							
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-1960		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE MAY 31 1960		24b. REGISTRAR'S SIGNATURE William S. Knaul	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Fairway Court		d. STREET ADDRESS 504 Fairway Court	
3. NAME OF DECEASED (Type or print) First Teresa Middle H. Last Irwin		4. DATE OF DEATH Month May Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1917
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Cutchin		14. MOTHER'S MAIDEN NAME Annie Luter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-9207	
17. INFORMANT Mrs. Donald Spencer-504 Fairway Ct.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lungs, Pleura 199.2 DUE TO metastatic from abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary site undetermined DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5, 1960 to May 3, 1960 that I last saw the deceased alive on May 2, 1960 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3009 EVERGREEN AVE MAY 31/60 DATE SIGNED ACTUAL SIGNATURE Donald W. Mintzer M.D. PHYSICIAN'S NAME (Type) DONALD W. MINTZER BALTIMORE 14 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 6, 1960	22c. NAME OF CEMETERY OR CREMATORY Blandford Cemetery	22d. LOCATION (City, town, or county) (State) Petersburg Va.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson		24a. REC'D BY REGISTRAR DATE. MAY 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5487

05465

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LONNIE Middle --- Last JEFFERSON				4. DATE OF DEATH Month May Day 29 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 20, 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.			
11. BIRTHPLACE (State or foreign country) Lynchburg, S. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOHN JEFFERSON				14. MOTHER'S MAIDEN NAME CARRIE MC DONALD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS 522X XPOXX DEHYDRATION, SEVERE Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 4 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign Prostatic Hypertrophy. Small Carcinoma of cecum							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 28 19 60 to May 29 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 29 19 60 , and that death occurred at 9:35 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.				22b. DATE SIGNED 5/30/60			
22c. PHYSICIAN'S NAME (Type or print) THOMAS R. HOOD, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. Md.				25a. REC'D BY REGISTRAR JUN 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2

1

CP

2487

CERTIFICATE OF DEATH

03102

Full Name

First Name

Date of Birth

Sex

Place of Birth

Occupation

Married

Spouse's Name

Death Date

Death Time

Signature

Witness Signature

Registrar

Registrar's Office

Division of Health Services, State of New York

Health Officer, County of New York

Health Officer, County of New York

Health Officer, County of New York

Health Officer, County of New York

Health Officer, County of New York

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5488

05466

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 6 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				e. STREET ADDRESS 3509 SPAULDING			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NELSON Middle JOHNSON Last JOHNSON				4. DATE OF DEATH Month MAY Day 31 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-29-1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 4 Hours 4 Min.		IF UNDER 24 HRS. Months 3 Days 1 Hours 4 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY HARDWARE		11. BIRTHPLACE (State or foreign country) SWEDEN	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-32-2793		17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-30 , 19 59 , to 5-30 , 19 60 , that (I) (we) last saw the deceased alive on 5-30 , 19 60 and that death occurred at 6:20 P. M., from the causes and on the date stated above.							
22a. SIGNATURE Walter T. Kees				22b. DATE SIGNED 5/31/60			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES				22d. ADDRESS COCKEYSVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-2-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2				25a. REC'D BY REGISTRAR DATE JUN 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05467

5489

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b ONE YEAR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIDGEWAY MANOR 5743 EDMONDSON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SOPHIE H. JOHNSON		4. DATE OF DEATH Month MAY Day 28 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. RAYMOND S. JOHNSON		Address 211 N. LUZERNE AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse - 782.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec , 19 58 , to May 28 , 19 60 , that I last saw the deceased alive on May 24 , 19 60 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Nelson McKay		ADDRESS (Street, city or town, state) 6014 Edmondson Ave. Baltimore 28 Md	
PHYSICIAN'S NAME (Type) J. NELSON MCKAY, M.D.		DATE SIGNED 5/29/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 31, 1960	22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.		24a. REC'D BY REGISTRAR DATE MAY 31 1960	
		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5490

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05468

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle -- Last JONES		4. DATE OF DEATH Month MAY Day 9 Year 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-12
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION CO.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MIKE JONES		14. MOTHER'S MAIDEN NAME MINNIE WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) (If yes, give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO. 705-09-0160	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOMA OF THE BRAIN, LEFT TEMPORAL LOBE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EDEMA OF LUNGS (c) BRONCHOPNEUMONIA, RIGHT LUNG		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 2 DAYS 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28 19 60 to May 9 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 9 19 60 , and that death occurred 6:50pm from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE SIGNED 5-10-60	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-13-1960	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips Funeral Home		25a. REC'D BY REGISTRAR MAY 12 '60	
25b. REGISTRAR'S SIGNATURE Chilwa S. Hanna			

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FOR STATE HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div>Item 18 Film 262 5-13-60</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>5469 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>																	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Life c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 615 Main Street						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 615 Main Street d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) GWENDOLYN JONES			4. DATE OF DEATH Month May Day 5 Year 1960			5. SEX Female			6. COLOR OR RACE Colored			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH June 24, 1951					
9. AGE (In years last birthday) 8 yrs.			10. IF UNDER 1 YEAR Months 8 Days 0			11. IF UNDER 24 HRS. Hours 0 Min. 0			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY Child					
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland						12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME John Jones						14. MOTHER'S MAIDEN NAME Dorothy Mae Holloway											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.						17. INFORMANT John Jones 615 Main St. Balto. 22, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PENDING Acute Bronchopneumonia DUE TO (b) Sickle cell disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) BALTIMORE, Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Wm. A. Jackson</i>												ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/5/60			
EXAMINER'S NAME (Type)												DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/9/60				22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.				22d. LOCATION (City, town, or country) (State) Baltimore 25 Maryland					
23. FUNERAL DIRECTOR Wm. A. Jackson Funeral Home 916 Penna. Ave.												24a. REC'D BY REGISTRAR MAY 9 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

FOR DEPT
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BUREAU OF PUBLIC HEALTH
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5492

CERTIFICATE OF DEATH

Reg. Dist. No. 05420

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1902

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Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to fading and bleed-through.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5493

Item 1 Birth 264 8-6-60 et

CERTIFICATE OF DEATH

05471

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Manor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville - Manor</u> <u>52</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5902 Cecil Avenue (At home)</u>				d. STREET ADDRESS <u>5902 Cecil Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLOTTE</u> Middle <u>M.</u> Last <u>KANE</u>				4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED SEPARATED DIVORCED		8. DATE OF BIRTH <u>July</u> <u>1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Cleaning</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City School Board</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>- Dailey</u>				14. MOTHER'S MAIDEN NAME <u>--</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>				16. SOCIAL SECURITY NO. <u>215-07-0335</u>		17. INFORMANT <u>Mr. Lloyd Kane - 5902 Cecil Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO <u>423.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1960</u> , to <u>May 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>May 25, 1960</u> , and that death occurred at <u>90 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Homer L. Todd</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Homer L. Todd</u>				22d. ADDRESS <u>2108 St Paul St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balt.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thayer</u>	



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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5494

CERTIFICATE OF DEATH

05472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7900 Aiken Avenue</u>		d. STREET ADDRESS <u>7900 Aiken Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. John C. Keister</u>		4. DATE OF DEATH <u>May 31st 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Balto City Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manor, Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ulysses Keister</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>214-40-4647</u>	
17. INFORMANT <u>Mrs. Catherine R. Keister</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Hypertensive Disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1953, to <u>May 31</u> , 1960, that I last saw the deceased alive on <u>Feb 12</u> , 1960, and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael J. Dausch</u> M.D. <u>4636 Belair Road, Balto. 6 Md</u>		DATE SIGNED <u>5/31/60</u>	
PHYSICIAN'S NAME (Type) <u>Michael J. Dausch</u>		<u>Baltimore, 6, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>JUN 2 '60</u>		DATE <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE, 19

NAME OF DECEASED JOHN A. ROBERTS		AGE 45		SEX Male		RACE White		DATE OF DEATH 1945		PLACE OF DEATH Home	
MARRIAGE Married		EDUCATION High School		OCCUPATION Teacher		RELIGION Roman Catholic		BIRTHPLACE Maryland		RESIDENCE Baltimore	
FATHER'S NAME John A. Roberts		MOTHER'S NAME Mary A. Roberts		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S BIRTHPLACE Maryland		MOTHER'S BIRTHPLACE Maryland	
DATE OF BIRTH 1900		PLACE OF BIRTH Maryland		DATE OF MARRIAGE 1920		PLACE OF MARRIAGE Baltimore		DATE OF DEATH 1945		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERMANENT DAMAGE None		TEMPORARY DAMAGE None		DATE OF EXAMINATION 1945		PLACE OF EXAMINATION Baltimore	
SIGNATURE OF PHYSICIAN Dr. J. A. Roberts		SIGNATURE OF CORONER J. A. Roberts		SIGNATURE OF WITNESS J. A. Roberts		SIGNATURE OF WITNESS J. A. Roberts		SIGNATURE OF WITNESS J. A. Roberts		SIGNATURE OF WITNESS J. A. Roberts	

RECEIVED
BALTIMORE, MARYLAND
1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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5495
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05473

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7		c. LENGTH OF STAY IN 1b X Baltimore 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7108 Campfield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEOLA Middle M. Last KINSTLER		4. DATE OF DEATH Month May Day 17, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1892
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Wash., D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward S. How		14. MOTHER'S MAIDEN NAME Mary Kelsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Roy W. Kinstler - 7108 Campfield Rd.		Address Balto. 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) (c) Chronic Myocarditis Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 month 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild C.V.A. - 1 wk.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 18th 1958 to May 12th 1960 , that (I) (we) last saw the deceased alive on May 16th 1960 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE James A. Miller M.D.		22b. DATE SIGNED 5/18/60	
22c. PHYSICIAN'S NAME (Type) James A. Miller M.D.		22d. ADDRESS 1331 Reisterstown Rd Pikesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION (City, town, or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto. 17		25a. REC'D BY REGISTRAR DATE MAY 19 60	
25b. REGISTRAR'S SIGNATURE William E. Hume			

05153

CERTIFICATE OF DEATH

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MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 14 FilmG263 5-19-60 et
5496
CERTIFICATE OF DEATH

05474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Allistan Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mrs.</i> Middle <i>Margaret V.</i> Last <i>Klein</i>		4. DATE OF DEATH Month <i>May</i> Day <i>11th</i> Year <i>19 60</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <i>EX</i> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 29, 1894</i>
9. AGE (In years lost birthday) <i>66</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>?</i>	
14. MOTHER'S MAIDEN NAME <i>Minderlein</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address <i>Mrs. Henry Horner Alliston Dr. Baldwin</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>CORONARY THROMBOSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Angina Pectoris</i> (c) <i>Hypertensive Cardiovas. Dis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 Wks.</i> <i>2 MONTHS</i> <i>5 Yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>— 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/13</i> , 19 <i>59</i> , to <i>5/11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/2</i> , 19 <i>60</i> , and that death occurred at <i>9:50 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clifford F. Hudson</i> M.D.		ADDRESS (Street, city or town, state) <i>FORK, M.D.</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/14/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 13 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5405

CERTIFICATE OF DEATH

05475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 36 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) 11822 Reisterstown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle May Last Knight				4. DATE OF DEATH Month May Day 17 Year 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5 1889	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Hendricks				14. MOTHER'S MAIDEN NAME Samanah Fleck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Elsie K Meekins Reisterstown Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none				20g. (County) none		20h. (State) none	
21. I certify that I attended the deceased from 7-6-38 , 19__, to 5-17-60 , 19__, that I last saw the deceased alive on 5-17-60 , 19__, and that death occurred at 6:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 5-19-60							
ACTUAL SIGNATURE D. D. Caples M.D.				PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 20 1960		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Berryman + Sons				ADDRESS Reisterstown Md		24a. REC'D BY REGISTRAR DATE MAY 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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5497
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05476

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 9 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1614 CAPE MAY ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle H. Last KNIGELY		4. DATE OF DEATH Month MAY Day 15 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 30, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AARON HAWKINS		14. MOTHER'S MAIDEN NAME ELIZABETH MICHAEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. ERWIN KRAIER Address ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 2 or 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus after 10 sclerosis, 4 diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1958 to 5/15 1960 , that (I) (we) last saw the deceased alive on 5/15 1960 , and that death occurred at 11:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE J. Blatt		22b. DATE SIGNED 5/16/60	
22c. PHYSICIAN'S NAME (Type) J. BLATT, M.D.		22d. ADDRESS Emory. md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-19-60	
23c. NAME OF CEMETERY OR CREMATORY BLACKSVILLE CEMETERY		23d. LOCATION (City, town, or county) (State) BLACKSVILLE PENNA.	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS Co. 4905 YORK RD.		25a. REC'D BY REGISTRAR MAY 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

05130

CERTIFICATE OF DEATH

2183

(M)

DATE OF DEATH

THE DECEASED

DATE OF BIRTH

PLACE OF BIRTH

1019 CATHAY ROAD

1019 CATHAY ROAD

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W. X. 1831 - 30

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

VS A15 24)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5498

CERTIFICATE OF DEATH

Reg. Dist. 05477

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHASE MD.		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 249 EBENEZER RD.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CAROLINE Middle M Last KNOCHE		4. DATE OF DEATH Month MAY Day 30 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 13, 1876
9. AGE (In years lost birthday) yrs. 84.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PHILLIP SCHAADT		14. MOTHER'S MAIDEN NAME CHRISTINE VOLTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MARIE M^cBRIDE		Address Box 249 EBENEZER RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) arteriosclerotic Cardio-Vascular disease DUE TO (c) 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 1960, to May 30, 1960 , that I last saw the deceased alive on May 29 , 1960, and that death occurred at 2:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) BALTO 6 MD DATE SIGNED 5/31/60 ACTUAL SIGNATURE M. Baumgardner M.D. PHYSICIAN'S NAME (Type) G. M. Baumgardner			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/2/1960	
22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM.		22d. LOCATION (City, town, or county) (State) BALTO CITY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd #6		24a. REC'D BY REGISTRAR DATE JUN 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

11-133

CERTIFICATE OF DEATH

2498

Baltimore

Maryland

Baltimore

Case No. 11-133

Deceased: *Caroline M. Jones*

Caroline M. Jones

61 KNOWN ST. BAL.

Date of Death: *Feb 12, 1902*

Place of Death: *Home*

Physician: *Christie W. Jones*

No. *11-133*

Caroline M. Jones

61 KNOWN ST. BAL.

Feb 12, 1902

Home

Christie W. Jones

11-133

Caroline M. Jones

61 KNOWN ST. BAL.

Feb 12, 1902

Home

Christie W. Jones

11-133

Caroline M. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5499

CERTIFICATE OF DEATH

Reg. Dist. No. 05478 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 824 S. Milton Avenue	
3. NAME OF DECEASED (Type or print) FRANK First STANLEY Middle KUCHAREK Last		4. DATE OF DEATH MAY Month 23 Day 19 Year 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.7. 1908.
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter on construction		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH KUCHAREK		14. MOTHER'S MAIDEN NAME FRANCES MARCEK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 212-09-5260	
17. INFORMANT Address Hospital Recd rds, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory pulmo- nary tuberculosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 14 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema. Pneumococcosis			
20a. ACCIDENT WAS UNDERWAY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-19 , 1955 , to 5. 23 , 1960 , that I last saw the deceased alive on May 23 , 1960 , and that death occurred at 11:12 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____			
ACTUAL SIGNATURE William Newcomer M.D.			
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-28-60	22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY	22d. LOCATION (City, town, or county) (State) BALTO. Co MD
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. WEBER & SONS INC		24a. REC'D BY REGISTRAR 401 S. CHESTER ST	
24b. REGISTRAR'S SIGNATURE Orthur S. Kraus		DATE MAY 25 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0513

CERTIFICATE OF DEATH

5893

Frank Stadel

Frank Stadel

Frank Stadel

FRANK STADEL

FRANK STADEL

FRANK STADEL

FRANK STADEL

FRANK STADEL

FRANK STADEL

JOSEPH KUCHANEK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5500

CERTIFICATE OF DEATH

05479

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (18) 3701.4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 3029 Saint Paul Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last LaCROIX			4. DATE OF DEATH Month May Day 11 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1893		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic- Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Euguen LaCroix			14. MOTHER'S MAIDEN NAME Ginny Bell Hughes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 215-05-7059		17. INFORMANT Clin.Rec.VAH, Balto.18,Md.Fort Howard Division
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF COLON WITH METASTASES TO LUNG 153.8 X1000X RIGHT ADRENAL AND LIVER Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) CACHEXIA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ (County) _____ (State) _____	
21. I certify that (a) (this hospital) attended the deceased from May 3 6:35 to May 11 19 60 , that (b) (we) last saw the deceased alive on May 11 19 60 , and that death occurred at p M, from the causes and on the date stated above.					
22a. SIGNATURE John D. Talbert			22b. DATE SIGNED 5/12/60		
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.			22d. ADDRESS VAH, BALTIMORE 18, MD.FT.HOWARD DIVISION		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/14/60		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
23d. LOCATION (City, town, or county) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. COOK-BLIGHT, INC.			25a. REC'D BY REGISTRAR MAY 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hulse
ADDRESS 6009 Harford Road Baltimore 14 Md					

05479

CERTIFICATE OF DEATH

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U.S.A.

31-1-1900

DEPARTMENT OF COMMERCE

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1900

1900

5511

CERTIFICATE OF DEATH

05480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3207 Whiteway Road				d. STREET ADDRESS 3207 Whiteway Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First THOMAS Middle EDWARD Last LAWLIS				4. DATE OF DEATH Month May Day 26th , Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1905	
9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR Months 5 Days 12 Hours 12 Min.		IF UNDER 24 HRS. Months 5 Days 12 Hours 12 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Orfey Lawlis				14. MOTHER'S MAIDEN NAME Dora ?? (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-07-8222		17. INFORMANT Irene Lawlis Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic congestive heart failure DUE TO Abdominal aneurysm - resected 3 years ago (c) Hypertensive arteriosclerotic heart disease 5 years.							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr 2 year 5 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 914 D Street	
20f. (City or town) Clarksburg, West Virginia				20g. (County) Clarksburg, West Virginia			
20h. (State) West Virginia							
21. I certify that I attended the deceased from July 1, 1958 , to May 26, 1960 , that I last saw the deceased alive on May 26, 1960 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John V. Conway, M.D.				ADDRESS (Street, city or town, state) 914 D Street			
DATE SIGNED 5/26/60							
PHYSICIAN'S NAME (Type) John V. Conway, M.D.				Sparrows Point 19, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/60		22c. NAME OF CEMETERY OR CREMATORY Floral Hills Memorial		22d. LOCATION (City, town, or county) (State) Clarksburg, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Jr.				ADDRESS Dundalk 22, Md		24a. REC'D BY REGISTRAR JUN 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5512 CERTIFICATE OF DEATH

05481

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2220 Barclay Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ONNA Middle L Last LESTER Jr.				4. DATE OF DEATH Month May Day 4 Year 1960			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1916	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Contracting		11. BIRTHPLACE (State or foreign country) Americus, Georgia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Onna L Lester, Sr				14. MOTHER'S MAIDEN NAME Mattie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 219-07-7533		17. INFORMANT Clin. Rec. VAH Balto 18, Md Ft Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 445X DUE TO MALIGNANT NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 Week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from May 2 11:55 PM to May 4 11:55 PM that 4 (we) last saw the deceased alive on May 4 1960 , and that death occurred at PM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas R. Hood				22b. DATE SIGNED May 4 1960			
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD M.D.				22d. ADDRESS VAH Balto 18, Md Ft Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips				25a. REC'D BY REGISTRAR DATE MAY 9 '60		25b. REGISTRAR'S SIGNATURE Arlington S. Phillips	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5513
CERTIFICATE OF DEATH

05482

1. PLACE OF DEATH a. COUNTY Baltimore				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 70 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 614 E. Fort Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) EUGENE F. LOWMAN				4. DATE OF DEATH Month MAY Day 13 Year 1960				5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH December 26, 1911				9. AGE (In years last birthday) 48 yrs.				10. IF UNDER 1 YEAR Months 48 Days 13 Hours 13 Min. 1960				11. IF UNDER 24 HRS. Months 48 Days 13 Hours 13 Min. 1960							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Company Maryland				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Guy K. Lowman				14. MOTHER'S MAIDEN NAME Rodella Newton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 217-07-6578				17. INFORMANT ClinRec VAH, Balto 18, Md. Ft. Howard Division				Address ClinRec VAH, Balto 18, Md. Ft. Howard Division			
18. CAUSE OF DEATH [Enter kind of cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT LUNG WITH WIDESPREAD METASTASES DUE TO EDEMA OF LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) EDEMA OF LUNGS (c) EDEMA OF LUNGS				INTERVAL BETWEEN ONSET AND DEATH Unknown 2 days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from March 4 19 60 to May 13 19 60 , that (we) last saw the deceased alive on May 13 19 60 , and that death occurred 5:10 AM from the causes and on the date stated above.				22a. SIGNATURE John D. Talbert M.D. JOHN D. TALBERT, M.D.				22b. DATE SIGNED 5/13/60				22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.				22d. ADDRESS VAH, BALTO 18, MD. FT HOWARD DIVISION				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-16-60				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE MC CULLY FUNERAL HOME, 130 E. Fort Ave. Balto 30, Md.				25a. REC'D BY REGISTRAR MAY 16 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. DATE MAY 16 '60				25d. ADDRESS MC CULLY FUNERAL HOME, 130 E. Fort Ave. Balto 30, Md.				25e. SIGNATURE Arthur S. Kraus																			

100-25

CERTIFICATE OF MARRIAGE

100-25



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5514

CERTIFICATE OF DEATH

05483
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS Cambridge Arms Apts. Charles & 34th Streets	
3. NAME OF DECEASED (Type or print) First George Middle M. Last Lyons		4. DATE OF DEATH Month May Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1889
9. AGE (In years last birthday) 71 yrs.		10. AGE (In years last birthday) 71 yrs.	11. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd) Executive		10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric Co	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Lyons		14. MOTHER'S MAIDEN NAME Mary Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-05-6585	
17. INFORMANT Mr. Gordon Lyons		Address 5200 Springlake Way,	
Zone 12		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 447X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchitis DUE TO Arteriosclerotic Hypertension (c) Arteriosclerotic Hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18 to May 18 , 19 60 , that I last saw the deceased alive on May 18 , 19 60 , and that death occurred at 9:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Geo. McLean		ADDRESS (Street, city or town, state) 705 Mes Apts	
PHYSICIAN'S NAME (Type) GEO. MCLEAN		DATE SIGNED Boet. Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-23-60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAY 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

GEO MCLEAN
 1007 New York
 New York
 May 18 10
 May 18 10

The following is a list of the
 names of the persons who
 were present at the meeting

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5515
CERTIFICATE OF DEATH
05484

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS 5502 Roland Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALLEN Middle L. Last MALONE		4. DATE OF DEATH Month May Day 16, Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1880
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager		10b. KIND OF BUSINESS OR INDUSTRY Continental Can	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME Joseph S. Malone		14. MOTHER'S MAIDEN NAME Kate Latta	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 091-03-6778	
17. INFORMANT Mrs. E. Morgan Loane		Address 5502 Roland Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis & Prostatic Carcinoma (c) Syncope INTERVAL BETWEEN ONSET AND DEATH 2 weeks ago			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 5/16 19 60 , that (I) (we) lost saw the deceased alive on 5/12 19 60 , and that death occurred at 7 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Franklin E. Teske		22b. DATE SIGNED 5/17/60	
22c. PHYSICIAN'S NAME (Type) Franklin E. Teske		22d. ADDRESS 2929 N. Charles St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Com.		23d. LOCATION (City, town, or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Baker & Sons - Balt.		25a. REC'D BY REGISTRAR May 17 '60	
25b. REGISTRAR'S SIGNATURE Charles J. Hines			

STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

SELF



Blank form with faint horizontal lines for text entry.



TO DECEASED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5394 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 218 Detroit Ave.				d. STREET ADDRESS 1 218 Detroit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle GEORGE Last MARQUARDT				4. DATE OF DEATH Month May Day 27 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-ret.		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork Seal		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Margurdt				14. MOTHER'S MAIDEN NAME Elizabeth Kaiser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-01-0304		17. INFORMANT Irvin Marquardt 6735 Pine Ave., -22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO A-S-C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis, M.D.				DATE SIGNED 5/28/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR DATE JUN 1 '60		24b. REGISTRAR'S SIGNATURE Clifford L. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5516

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05486

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford				c. LENGTH OF STAY IN 1b X				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3705 Buckingham Rd.				d. STREET ADDRESS 3705 Buckingham Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First OLIVE Middle F. Last MARSHALL				4. DATE OF DEATH Month May Day 7 Year 1960											
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1890		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry W. Fellingame				14. MOTHER'S MAIDEN NAME Arabelle Buckworth											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. Henry Fellingame - 1602 Waverly Way				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis, left DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO disease (c) known for 7 yrs INTERVAL BETWEEN ONSET AND DEATH 4 Mos															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from November 1953 to 7 May , 19 60 , that (I) was last saw the deceased alive on 7 May , 19 60 , and that death occurred at 3P M, from the causes and on the date stated above.															
22a. SIGNATURE Marvin H. Davis				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 6512 Liberty Road, Balto. 7, Md.				22b. DATE SIGNED 9 May 1960							
22c. PHYSICIAN'S NAME (Type) Marvin H. Davis, M. D.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/9/60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.				23d. LOCATION (City, town, or county) (State) Woodlawn, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner				ADDRESS Yours - Balto. 7 Md.				25a. REC'D BY REGISTRAR DATE MAY 10 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus					

CERTIFICATE OF DEATH

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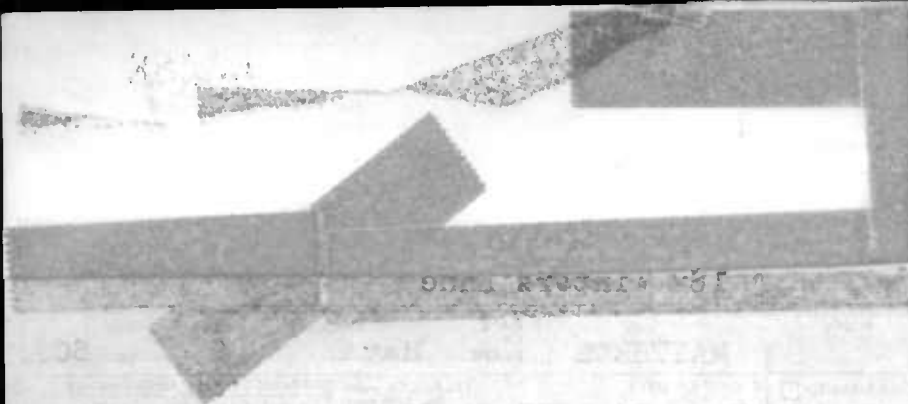
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MARYLAND STATE DEPARTMENT OF HEALTH
5517 **CERTIFICATE OF DEATH**

05187

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 162 Winters Lane				d. STREET ADDRESS 162 Winters Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARY		First		Middle		Last	
4. DATE OF DEATH May		Month		Day		Year	
		9		19		60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1873		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Adams				14. MOTHER'S MAIDEN NAME Laura ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Mamie Williams 162 Winters Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arterio-sclerotic Heart Disease DUE TO & Mitral Insufficiency I4 yrs. 3 mo. 4 days (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Hemiplegia 5yrs 10 Mo. 12 days							
INTERVAL BETWEEN ONSET AND DEATH 9 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5th, 1946 , to May 9th, 1960 , that I last saw the deceased alive on May 9th, 1960 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. F. Maloney M.D. 57 Winters Lane 5-9-60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) C. F. Maloney, M.D. Catonsville, 28. Md							
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 5-12-60		22c. NAME OF CEMETERY OR CREMATORY Western Star Cem		22d. LOCATION (City, town, or county) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Frances H. Hensley				ADDRESS 578 W. Biddle St.		24a. REC'D BY REGISTRAR MAY 12 '60	
				24b. REGISTRAR'S SIGNATURE <i>C. J. Hawk</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5518

CERTIFICATE OF DEATH

05488

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 13 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle A Last McCLUSKEY				4. DATE OF DEATH Month MAY Day 11 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-21-90	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —		11. IF UNDER 24 HRS. Months — Days — Hours — Min. —		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND, BALTIMORE			
11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MICHAEL A McCLUSKEY				14. MOTHER'S MAIDEN NAME ANNA HEALEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-1 215-34-7298			
17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF LUNGS 141.9 Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) CACHEXIA (c) STATUS POST HEMIGLOSSECTOMY, CARCINOMA OF TONGUE							INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT DEATH, OR INTERMITTENT DISEASE CONDITION GIVEN IN PART I (a) Operation March 1954. John Hopkins Hospital, Baltimore, Md.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28 , 19 60 , to May 11 , 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 11 , 19 60 , and that death occurred at 3:10pm from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert, M.D.				22b. DATE SIGNED 5-12-60		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.	
22d. ADDRESS VAH, BALTIMORE, 18, MD. FT. HOWARD DIVISION				22e. DATE SIGNED 5-12-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-14-60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE SCHIMUNEK FUNERAL HOME				25a. REC'D BY REGISTRAR 3331 Brehem's Lane		25b. REGISTRAR'S SIGNATURE Baltimore 13 Md	
25a. REC'D BY REGISTRAR DATE MAY 13 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5519

CERTIFICATE OF DEATH

05489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		c. LENGTH OF STAY IN 1b Rockdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3513 Jean Drive		d. STREET ADDRESS 3513 Jean Drive #7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle WILLIAM Last McINTIRE		4. DATE OF DEATH Month May Day 7 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Kent County, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joshua Bruce McIntire		14. MOTHER'S MAIDEN NAME Margaret Ann Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mrs. Clara E. McIntire-3513 Jean Drive #7		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA, INTRA-ABDOMINAL 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALUNION, FRACTURE OF NECK OF RIGHT FEMUR INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FALL 1958 to MAY '7 , 1960, that I last saw the deceased alive on MAY 6 , 1960, and that death occurred at 12:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Marvin Goldstein		ADDRESS (Street, city or town, state) 5334 LIBERTY HEIGHTS AVE DATE SIGNED 5/7/60	
PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN		BALTO. 7, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/10/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE amg. (ickner) Balto-12. Md.		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
24b. REGISTRAR'S SIGNATURE Richard S. Knead			

235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
5520 CERTIFICATE OF DEATH 05490										
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 7</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 7</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8339 Liberty Rd.</u>					d. STREET ADDRESS <u>8339 Liberty Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>ALBERT</u>			First <u>L.</u> Middle <u>MEHRLING</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 12, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Official</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry L. Mehrling</u>					14. MOTHER'S MAIDEN NAME <u>Mary A. Adams</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mary A. Mehrling - 8339 Liberty Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-7</u> 19 <u>57</u> to <u>5-21</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> 19 <u>60</u> , and that death occurred at <u>18</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>B. Stanley Cohen</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-23-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. Stanley Cohen, M.D.</u>					22d. ADDRESS <u>7306 Liberty Road Baltimore 7, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Son</u>					ADDRESS <u>Baltimore 7, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Tiekner</u>	

05400

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2280

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1 day
5 years



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5521

CERTIFICATE OF DEATH

05491

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NORTH CAROLINA b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 98 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle H Last MENDENHALL				4. DATE OF DEATH Month MAY Day 12 Year 19 60			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 2, 1897	
9. AGE (In years lost birthday) yrs. 63		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOOD & METAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY Construction Co		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HAMOND MENDENHALL		14. MOTHER'S MAIDEN NAME TEMPLE MONTGOMERY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION DUE TO CARCINOMA OF THE STOMACH Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that MD (this hospital) attended the deceased from FEBRUARY 4, 19 60 to MAY 12, 19 60 that X (we) last saw the deceased alive on MAY 12, 19 60 , and that death occurred 10:00 am from the causes and on the date stated above.							
22a. SIGNATURE <i>John D. Talbert</i>				22b. PHYSICIAN'S NAME (Type) JOHN D. TALBERT		22c. DATE SIGNED 5/13/60	
22d. ADDRESS VAH FT HOWARD, MD				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5-13-1960		23c. NAME OF CEMETERY OR CREMATORY MAPLE WOOD CEMETERY		23d. LOCATION (City, town, or county) (State) GREENSBORO NORTH CAROLINA	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips				25a. REC'D BY REGISTRAR MAY 20 60		25b. REGISTRAR'S SIGNATURE <i>Arlington S. Phillips</i>	

SHIP TO: HARGETT FUNERAL HOME GREENSBORO, NORTH CAROLINA

02491

CERTIFICATE OF DEATH

2521

DECEASED PERSON

HOSPITAL

DATE OF DEATH

AGE

PLACE OF BIRTH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

SEX

RACE

DATE OF BIRTH

AGE

PLACE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05492

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 6			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8200 Pulaski				d. STREET ADDRESS 8200 Pulaski Highway			
3. NAME OF DECEASED (Type or print) JAMES C. MERDITH				4. DATE OF DEATH Month May Day 5 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 2, 1909		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mose A. Meredith				14. MOTHER'S MAIDEN NAME Susan Drout			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO.		17. INFORMANT John J. Meredith, 407 Mt. Washington Street Alexandria Va			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial infarct. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home PARTIAL		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Wm. Cook</i> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 5, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-9-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or country) (State) Arlington Virginia	
23. FUNERAL DIRECTOR William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAY 9 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05493

5523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armcast N.H., Sherwood & Regester</u>		d. STREET ADDRESS <u>408 Aigburth Ave.</u> 4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN N MERKLE</u>		4. DATE OF DEATH Month Day Year <u>May 5 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1894</u>
9. AGE (In years last birthday) yrs. <u>66</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John N. Merkle</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-7360</u>	
17. INFORMANT <u>John N. Merkle</u>		Address <u>115 Overbrook Rd 12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Renal</u> DUE TO <u>Vascular Disease</u> (c) <u>10410</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19 51</u> to <u>May 5 1960</u> , that I last saw the deceased alive on <u>May 3 1960</u> , and that death occurred at <u>7:17</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd 5, Md.</u> DATE SIGNED <u>5/7/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D. Towson Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/9/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Mem. Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Timonium Balto Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson Inc.</u>		ADDRESS <u>1050 York Rd 4</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

5524

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05494

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie Schellhas Merryman		4. DATE OF DEATH Month May Day 30 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1886
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Schellhas		14. MOTHER'S MAIDEN NAME Bertha	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. George Klinefelter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinoma with general metastases DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/10/58 19 to 5/22/60 19, that (I) (we) lost the deceased alive on 5/22/60 19, and that death occurred at AM , from the causes and on the date stated above.			
22a. SIGNATURE Milton Schlenoff		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Milton Schlenoff		22d. ADDRESS 6410 Windsor Mill Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-2-60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR JUN 2 '60	
25b. REGISTRAR'S SIGNATURE Charles S. House			

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IF NECESSARY, please see
 Director, Page 4 should be
 determined for your files.
 prior to burial, cremation

IF NECESSARY, please see
 Director, Page 4 should be
 determined for your files.
 prior to burial, cremation

5525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balts</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>52 Catonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6118 Old Federal Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Bennett</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>Neuro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3 1903</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Bennett Bridgford</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Hips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Charles Morris, Old Federal Rd</u> Address <u>6118</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular disease</u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>5-31-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Johnson, 1011 N. Arlington Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hirsch</u>	

MEDICAL CERTIFICATION

TO be cut out and forwarded to the FUNERAL DIRECTOR: Page 2 or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

5526

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home Paradise and Altamont Avenues		d. STREET ADDRESS 4805 Norwood Avenue	
3. NAME OF DECEASED (Type or print) First Mary Middle Carter Last Mowry		4. DATE OF DEATH Month May Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Myers		14. MOTHER'S MAIDEN NAME Mary MacRorie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address Edward Walton, 1st Nat'l Bank Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. **** p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) (County) (State) *****	
21. I certify that I attended the deceased from 19 50 , to 4 May , 19 60 that I last saw the deceased alive on 4 May , 19 60 , and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5101 Gwynn Oak Ave. DATE SIGNED 5/6/60 ACTUAL SIGNATURE Millard T. Traband, Jr. M.D. Baltimore, 7, Md. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-6-60	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR MAY 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2550

1

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5527

CERTIFICATE OF DEATH

Reg. Dist. No.

06670

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynn Acres, Balto. 7 c. LENGTH OF STAY IN 1b 6 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Balto. 7 (Lynn Acres) d. STREET ADDRESS 3444 Ripple Road e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) William O. Mullinix		4. DATE OF DEATH 10.30 P.M. 5 31 19 60	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Vie. Pres.		10b. KIND OF BUSINESS OR INDUSTRY Woodbine Nat. Bank	
11. BIRTHPLACE (State or foreign country) Carroll Co; Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ***** None	
17. INFORMANT Mrs. Edith V. Mullinix		Address 3444 Ripple Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) more than 5 years		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1955 to 31 May 1960 , that I last saw the deceased alive on 14 January 1960 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6512 Liberty Road, Balto. 7, Md. DATE SIGNED Dr. Marvin H. Davis			
ACTUAL SIGNATURE Dr. Marvin H. Davis		M.D. 6512 Liberty Road, Balto. 7, Md.	
PHYSICIAN'S NAME (Type) Dr. Marvin H. Davis		6512 Liberty Road, Balto. 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/60	
22c. NAME OF CEMETERY OR CREMATORY Marshall Chapel Church Cem.		22d. LOCATION (City, town, or county) (State) Carroll Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		24a. REC'D BY REGISTRAR JUN 7 '60	
ADDRESS 8728 Liberty Road		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	
Randallstown, Md.			

CERTIFICATE OF DEATH

3557

Name of Deceased		Age		Sex		Race	
John A. Smith		45		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
Jan 15, 1950		Home		Heart Disease		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Burial	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report		Manner of Report	
Jan 16, 1950		Home		Heart Disease		Natural	



1. Name of Deceased
2. Age
3. Sex
4. Race
5. Date of Death
6. Place of Death
7. Cause of Death
8. Manner of Death
9. Signature of Physician
10. Signature of Registrar
11. Signature of Informant
12. Signature of Burial
13. Date of Report
14. Place of Report
15. Cause of Report
16. Manner of Report

5528

CERTIFICATE OF DEATH

05497
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford		c. LENGTH OF STAY IN 1b X Milford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7217 Rockridge Road		d. STREET ADDRESS 7217 Rockridge Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First Middle Last SLEMER MUNCASTER	
4. DATE OF DEATH May 18,		Month Day Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/'71
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Willson		14. MOTHER'S MAIDEN NAME Anna Gilpin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Helen Rice-Germantown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) - Broncho - Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (2) - Arterio - Sclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial Intestinal Obstruction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1960 to May 18, 1960 , that I last saw the deceased alive on May 17, 1960 , and that death occurred at 6:09 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts. Bldg. - Baltimore - Md.	
DATE SIGNED 5-18-60			
PHYSICIAN'S NAME (Type) EARL L. CHAMBERS - M.D.		4108 LIBERTY HIGHS AVE.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/60	
22c. NAME OF CEMETERY OR CREMATORY Rockville		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		ADDRESS 1331 E. Montgomery Avenue Rockville, Md.	
24a. REC'D BY REGISTRAR MAY 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5288

CERTIFICATE OF DEATH

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]



5329

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3mth12dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>1131 Ridgley Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Nelson</u> Last <u>Nelson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>19 60</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 4, 1880</u>	9. AGE (In years last birthday) <u>80 yrs.</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>902.0</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO <u>Fracture left femur</u> (c) <u>Accident</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>On 12-16-59 open reduction and Smith-Peterson nailing performed at University Hospital</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>ON 12-14-59 while at home, patient fell from a low kitchen chair sustaining a frac. of left hip.</u>					
20c. TIME OF INJURY Hour <u>?</u> a. m. <u>12-14-59</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>1131 Ridgley Street</u> (County) <u>Baltimore</u> (State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>George M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowans Inc. Hollins</u>				24a. REC'D BY REGISTRAR <u>MAY 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DECEASED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF BIRTH _____		SEX _____	
DATE OF BIRTH _____		DATE OF DEATH _____	
PLACE OF DEATH _____		TIME OF DEATH _____	
NAME OF DECEASED _____		NAME OF EXAMINER _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		PREVIOUS ILLNESSES _____	
TREATMENT _____		POST-MORTEM _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF DECEASED _____	
WITNESSES _____		CORONER _____	
COUNTY _____		CITY _____	
STATE _____		ZIP CODE _____	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5530 CERTIFICATE OF DEATH

05499

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1625 N. Milton Avenue			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM E. Middle E. Last NORRIS				4. DATE OF DEATH Month May Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1914		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Automobile Co.		11. BIRTHPLACE (State or foreign country) Whitestone, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Norris				14. MOTHER'S MAIDEN NAME Cora MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216-07-9735		17. INFORMANT Address Clin/Rec.VAH, BALTO.18,MD.,FT.HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS DUE TO HYPERTROPHY AND DILATATION OF THE HEART (b) MALIGNANT NEPHROSCLEROSIS DUE TO MALIGNANT NEPHROSCLEROSIS (c) MALIGNANT NEPHROSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 18 1960 to May 23 1960 , that (X) (we) last saw the deceased alive on May 23 1960 , and that death occurred at 6:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas R. Hood M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/23/60	
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.				22d. ADDRESS VAH, BALTO.18 MD, FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE THEREOF 5-26-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson				ADDRESS Kelson Fun. Home, 1348 N. Calhoun St.		25a. REC'D BY REGISTRAR MAY 24 '60	
				25b. REGISTRAR'S SIGNATURE Carlton L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DATE OF DEATH

2230



(1)

U. S. ARMY

ARMY

Colonel

Mr. E.

U. S. ARMY

U. S. ARMY

U. S. ARMY

U. S. ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
5531					CERTIFICATE OF DEATH					05500				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 53 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					d. STREET ADDRESS 508 Sudbrook Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First EARL Middle Clarence Last NOST					4. DATE OF DEATH Month MAY Day 1ST Year 19 60									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/31/98		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Mariner			10b. KIND OF BUSINESS OR INDUSTRY Shipping Co.			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Axil Nost					14. MOTHER'S MAIDEN NAME Laura Hammer									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW I					16. SOCIAL SECURITY NO. 549-24-8464					17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO 177X ARTERIOSCLEROTIC HEART DISEASE ADENOCARCINOMA, PROSTATE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXXX METASTATIC ADENOCARCINOMA, BONES (Prostate) HYDRONEPHROSIS, BILATERAL (Due to Adenocarcinoma) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenomata, adrenals, old. Granuloma, left lung, old.										INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9 19 60 , to May 1 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 1 19 60 , and that death occurred at 7:10 PM from the causes and on the date stated above.														
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/2/60							
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.					22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/4/60		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d. LOCATION (City, town, or county) Baltimore, Maryland (State)						
24. FUNERAL DIRECTOR'S SIGNATURE Tickner Funeral Home. Baltimore, Maryland					25a. REC'D BY REGISTRAR DATE MAY 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

02 30 03 04

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CERTIFICATE OF DEATH

05501
Reg. Dist. No.

5532

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE	c. LENGTH OF STAY IN 1b 5 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 VOL. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 4609 YORK ROAD	
3. NAME OF DECEASED (Type or print) First GEORGE Middle PHILIP Last OHLGART		4. DATE OF DEATH Month MAY Day 3 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months 8 Days 7 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME WILLIAM OHLGART		14. MOTHER'S MAIDEN NAME ELIZA BETH SCHWAMB	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-6967	
17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardio Vas. disease DUE TO (c) 5 years			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-2 , 19 55 , to 5-2 , 19 60 , that I last saw the deceased alive on 5-2 , 19 60 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter T. Kees		ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 5/3/60	
PHYSICIAN'S NAME (Type) WALTER T. KEES		COCKEYSVILLE MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-6-60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAY 6 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5533

CERTIFICATE OF DEATH

05502

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>406 Frederick Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Peter A. Olson</u> First Middle Last		4. DATE OF DEATH <u>May 11</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/77</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired C.P. Sulphon Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ole Olson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Olson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Rachel Olson</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Chronic Brain Syndrome with</u> DUE TO <u>334x</u> <u>Associated Arteriosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>② Degenerative Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>5/11/60</u> , that (I) (we) last saw the deceased alive on <u>5/10/60</u> , and that death occurred on <u>5/11/60</u> AM, from the causes and on the date stated above.		22a. SIGNATURE <u>W. E. McGrath</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>W. E. McGrath</u>		22d. ADDRESS <u>1303 Frederick Rd Catonsville Md</u>	
22b. DATE SIGNED <u>5/12/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/14/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Balt. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>MacNabb & Son</u>		ADDRESS <u>28</u>	
25a. REC'D BY REGISTRAR <u>MAY 12 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 6263 5-19-60 et

CERTIFICATE OF DEATH

5534

05503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>920 YANDERWOOD RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Joseph PALMISANO</u>				4. DATE OF DEATH Month Day Year <u>MAY 14 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3, 1925</u>		9. AGE (In years last birthday) <u>34</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE BUYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRODUCE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony PALMISANO</u>				14. MOTHER'S MAIDEN NAME <u>Josephine (last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>219-18-1853</u>		INFORMANT Address <u>Dorothy PALMISANO 920 Vanderwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>414X Cardiac-Respiratory failure</u> DUE TO (b) <u>Cardiac arrhythmia</u> DUE TO (c) <u>Rheumatic Endocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral Valvular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 April</u> , 19 <u>60</u> , to <u>14 May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>14 May</u> , 19 <u>60</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William J. Bryson</u> M.D.				ADDRESS (Street, city or town, state) <u>4605 Edmondson</u> DATE SIGNED <u>14 May 60</u>			
PHYSICIAN'S NAME (Type) <u>William J. Bryson</u>				BALTO 29 MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-17-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEO. L. SCHWAB Funeral Home</u> ADDRESS <u>Francis St. & Miller 2101 Frederick Ave.</u>				24a. REC'D BY REGISTRAR <u>MAY 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

1. Name of deceased John Doe
2. Age 45
3. Sex Male
4. Date of death Jan 15 1900
5. Place of death Home
6. Cause of death Heart Disease
7. Signature of physician J. H. Smith
8. Signature of registrar W. B. Jones
9. Signature of undertaker C. L. Brown
10. Signature of witness A. M. Green
11. Signature of witness F. D. White
12. Signature of witness H. K. Black
13. Signature of witness L. P. Grey
14. Signature of witness M. R. Blue
15. Signature of witness N. T. Yellow
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519. Signature of witness X. D. Yellow
520. Signature of witness Y. E. Purple
521. Signature of witness Z. F. Pink
522. Signature of witness A. G. Red
523. Signature of witness B. H. Orange
524. Signature of witness C. I. Green
525. Signature of witness D. J. Blue
526. Signature of witness E. K. Yellow
527. Signature of witness F. L. Purple
528. Signature of witness G. M. Pink
529. Signature of witness H. N. Red
530. Signature of witness I. O. Orange
531. Signature of witness J. P. Green
532. Signature of witness K. Q. Blue
533. Signature of witness L. R. Yellow
534. Signature of witness M. S. Purple
535. Signature of witness N. T. Pink
536. Signature of witness O. U. Red
537. Signature of witness P. V. Orange
538. Signature of witness Q. W. Green
539. Signature of witness R. X. Blue
540. Signature of witness S. Y. Yellow
541. Signature of witness T. Z. Purple
542. Signature of witness U. A. Pink
543. Signature of witness V. B. Red
544. Signature of witness W. C. Orange
545. Signature of witness X. D. Green
546. Signature of witness Y. E. Blue
547. Signature of witness Z. F. Yellow
548. Signature of witness A. G. Purple
549. Signature of witness B. H. Pink
550. Signature of witness C. I. Red
551. Signature of witness D. J. Orange
552. Signature of witness E. K. Green
553. Signature of witness F. L. Blue
554. Signature of witness G. M. Yellow
555. Signature of witness H. N. Purple
556. Signature of witness I. O. Pink
557. Signature of witness J. P. Red
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561. Signature of witness N. T. Yellow
562. Signature of witness O. U. Purple
563. Signature of witness P. V. Pink
564. Signature of witness Q. W. Red
565. Signature of witness R. X. Orange
566. Signature of witness S. Y. Green
567. Signature of witness T. Z. Blue
568. Signature of witness U. A. Yellow
569. Signature of witness V. B. Purple
570. Signature of witness W. C. Pink
571. Signature of witness X. D. Red
572. Signature of witness Y. E. Orange
573. Signature of witness Z. F. Green
574. Signature of witness A. G. Blue
575. Signature of witness B. H. Yellow
576. Signature of witness C. I. Purple
577. Signature of witness D. J. Pink
578. Signature of witness E. K. Red
579. Signature of witness F. L. Orange
580. Signature of witness G. M. Green
581. Signature of witness H. N. Blue
582. Signature of witness I. O. Yellow
583. Signature of witness J. P. Purple
584. Signature of witness K. Q. Pink
585. Signature of witness L. R. Red
586. Signature of witness M. S. Orange
587. Signature of witness N. T. Green
588. Signature of witness O. U. Blue
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592. Signature of witness S. Y. Red
593. Signature of witness T. Z. Orange
594. Signature of witness U. A. Green
595. Signature of witness V. B. Blue
596. Signature of witness W. C. Yellow
597. Signature of witness X. D. Purple
598. Signature of witness Y. E. Pink
599. Signature of witness Z. F. Red
600. Signature of witness A. G. Orange
601. Signature of witness B. H. Green
602. Signature of witness C. I. Blue
603. Signature of witness D. J. Yellow
604. Signature of witness E. K. Purple
605. Signature of witness F. L. Pink
606. Signature of witness G. M. Red
607. Signature of witness H. N. Orange
608. Signature of witness I. O. Green
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615. Signature of witness P. V. Green
616. Signature of witness Q. W. Blue
617. Signature of witness R. X. Yellow
618. Signature of witness S. Y. Purple
619. Signature of witness T. Z. Pink
620. Signature of witness U. A. Red
621. Signature of witness V. B. Orange
622. Signature of witness W. C. Green
623. Signature of witness X. D. Blue
624. Signature of witness Y. E. Yellow
625. Signature of witness Z. F. Purple
626. Signature of witness A. G. Pink
627. Signature of witness B. H. Red
628. Signature of witness C. I. Orange
629. Signature of witness D. J. Green
630. Signature of witness E. K. Blue
631. Signature of witness F. L. Yellow
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633. Signature of witness H. N. Pink
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635. Signature of witness J. P. Orange
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638. Signature of witness M. S. Yellow
639. Signature of witness N. T. Purple
640. Signature of witness O. U. Pink
641. Signature of witness P. V. Red
642. Signature of witness Q. W. Orange
643. Signature of witness R. X. Green
644. Signature of witness S. Y. Blue
645. Signature of witness T. Z. Yellow
646. Signature of witness U. A. Purple
647. Signature of witness V. B. Pink
648. Signature of witness W. C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5535

CERTIFICATE OF DEATH

05504

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 59 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 524 North Bouldin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last FRANK M. PANOWICZ				4. DATE OF DEATH Month Day Year May 6 19 60											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1915		9. AGE (In years last birthday) yrs. 45		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drawbridge Operator				10b. KIND OF BUSINESS OR INDUSTRY City Bridges				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John S. Panowicz				14. MOTHER'S MAIDEN NAME Mary Roszyk											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 217-07-4408				17. INFORMANT Address Clin.Rec.VAH, Balto.18,Md. Ft.Howard Division							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA, LEFT LUNG DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that 1/1 (this hospital) attended the deceased from March 8 1960 to May 6 1960 , that 1/1 (we) last saw the deceased alive on May 6 1960 , and that death occurred at 10:15AM from the causes and on the date stated above.															
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.										22b. DATE 5/6/60 SIGNED					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/10/60		23c. NAME OF CEMETERY OR CREMATORY Saint Stanislaus Cemetery Baltimore				23d. LOCATION (City, town, or county) (State) 22, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozazewski						25a. REC'D BY REGISTRAR 1930 Eastern Ave. Baltimore, Maryland				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna					
25a. DATE MAY 10 '60															

CERTIFICATE OF DEATH

5535

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5536
CERTIFICATE OF DEATH
05505

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4714 Pimlico Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUST Middle L. Last PARKER		4. DATE OF DEATH Month May Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 17, 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Frederick Parker		14. MOTHER'S MAIDEN NAME Mary Sophie Sang	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 218-07-9809	
17. INFORMANT Clin. Records VAH, Balto. Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 522X INDEX CARCINOMA OF THE PANCREAS WITH METASTASIS TO THE LIVER, LUNGS AND ADRENAL GLANDS (b) UNKNOWN (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xx (this hospital) attended the deceased from October 9, 1959 to May 27, 1960 , that x (we) last saw the deceased on May 27, 1960 and that death occurred at 1:55 PM from the causes and on the date stated above.		22a. SIGNATURE Harold R. Johnson M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION 5/28/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. 6009 Harford Rd. Balto. Md.		25a. REC'D BY REGISTRAR DATE JUN 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5537

CERTIFICATE OF DEATH

05506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Henry Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle Q. Last Pensel		4. DATE OF DEATH Month May Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman-Retired		10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Pensel		14. MOTHER'S MAIDEN NAME Annie Knight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-6105	
INFORMANT Mrs. Nettie A. Pensel		Address 5 Henry Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Cardiovascular Disease (c) Diabetes Mellitus.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-29 , 19 57 , to 5-5 , 19 60 , that I last saw the deceased alive on 4-20-60 , 19 60 , and that death occurred at 2 pm , from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Hyle		DATE SIGNED 5-6-60	
PHYSICIAN'S NAME (Type) JOHN C. Hyle		ADDRESS (Street, city or town, state) 7527 Belair Rd. Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith	22d. LOCATION (City, town, or county) (State) Trump Mill Rd. Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR DATE MAY 11 '60	24b. REGISTRAR'S SIGNATURE William S. Hanna

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Cleared by Dr. Betty Dpty Med Examiner, plus 5-5-60

VS A15 (4)
15M 9/58

5537

CERTIFICATE OF DEATH

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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5538

05507

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>53</u> <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>115 Smithwood Ave</u>		d. STREET ADDRESS <u>115 Smithwood Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John H. Pepples</u> First Middle Last		4. DATE OF DEATH <u>May 3 1960</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12/96</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Transit Co</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. (Dr.)</u>		14. MOTHER'S MAIDEN NAME <u>Nagel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215103935</u>	
17. INFORMANT <u>Dr. Agnes T. Pepples</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ac. coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 28 1960</u> to <u>May 3 1960</u> , that (I) (we) last saw the deceased alive on <u>May 2 1960</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Justinas Kudirka</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Justinas KUDIRKA</u>		22d. ADDRESS <u>1707 Edmonson Ave Baltimore 28, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/6/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. R. ... Son</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 6 '60</u>	
ADDRESS <u>28</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1888



John Doe
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5539 **CERTIFICATE OF DEATH**

05508

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle E. Last PHILLIPS				4. DATE OF DEATH Month May Day 25 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1900		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stamping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Pocomoke City, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Phillips				14. MOTHER'S MAIDEN NAME Margaret Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 212-22-2104		17. INFORMANT Address Clin. Rec., VAH, Baltimore 18, Md., Ft. Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO CEREBRAL ARTERIOSCLEROSIS (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. HYPERTENSIVE VASCULAR DISEASE (c)						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23 1960 to May 25 1960 , that (I) (we) lost 3:30AM the deceased alive on May 25 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.				22b. DATE SIGNED 5/25/60			
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.				22d. ADDRESS VAH, BALTO. 18, MD., FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips 1808 N. Monroe St. Balto. 17, MD.				25a. REC'D BY REGISTRAR MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02208

STATE OF TEXAS

02208



IN SENATE,
January 11, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.



Presented to the
Senate at its
regular session,
January 11, 1901,
by
J. W. WALKER,
COMMISSIONER.

John W. Walker

Printed by
J. W. WALKER,
COMMISSIONER.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5540

CERTIFICATE OF DEATH

05509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO 27</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ENGLISH COUNSEL</u>				c. LENGTH OF STAY IN b. <u>YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3018 ALABAMA AVE</u>				d. STREET ADDRESS <u>13018 ALABAMA AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>RENA</u> First <u>U. POPESKO</u> Middle <u>LOST</u> Last				4. DATE OF DEATH <u>MAY</u> 8 Day <u>1960</u> Year			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 March 1884</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>TAILOR (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING (WHL)</u>		11. BIRTHPLACE (State or foreign country) <u>Austria Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KOSTA VUKOVAN</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>15-01-8809</u>		17. INFORMANT Address <u>ROSALINE V. ORNDORFF 3018 ALABAMA AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>60</u> , to <u>May 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>60</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Schmiedel</u> M.D.				ADDRESS (Street, city or town, state) <u>2301 Annapolis Rd</u> DATE SIGNED <u>5/9/60</u>			
PHYSICIAN'S NAME (Type) <u>PAUL SCHMIEDEL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11 MAY 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOUDON PARK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. C. Walters</u> ADDRESS <u>Burg Street</u>				24a. REC'D BY REGISTRAR <u>MAY 10 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5541

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8313 Belair Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wm. Andrew Potts</u>		4. DATE OF DEATH Month Day Year <u>May 26, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1914</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. A. Potts</u>		14. MOTHER'S MAIDEN NAME <u>Emma Krumholtz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-14-3668</u> INFORMANT <u>Mrs. Marie C. Potts</u> Address <u>8313 Belair Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Maligant hypertension</u> DUE TO <u>Maligant hypertension</u> (c) <u>Cerebral thrombosis</u> DUE TO <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7/25 A</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/27/60</u> to <u>5/26, 60</u> , that I last saw the deceased alive on <u>5/26-60</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>F. Fred. Ruzic</u> M.D.			
PHYSICIAN'S NAME (Type) <u>F. Fred. Ruzic</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sassahn Funeral Home</u> ADDRESS <u>7401 Belair Road #6</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hersh</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

0001

CERTIFICATE OF DEATH

2541

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12 & 14 Film G262 5/11/60 iwk

05511

5542

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home				d. STREET ADDRESS 2320 Jefferson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wasil L. Prihodich (Also Prigidich) First Middle Last				4. DATE OF DEATH May 3, 1960 Month Day Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1894	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevadore				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? Russia ✓							
13. FATHER'S NAME Wasil Prihodich				14. MOTHER'S MAIDEN NAME Mary unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none				16. SOCIAL SECURITY NO. 216-07-7555			
17. INFORMANT Anastasia Prihodich				Address 2320 Jefferson St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Crown Artery Insufficiency (b) Unknown (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Concussion of the Esophagus							
INTERVAL BETWEEN ONSET AND DEATH 3 hrs 3 hrs Unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/12 , 19 60 , to 5/13 , 19 60 , that I last saw the deceased alive on 5/13/60 , and that death occurred at 1:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4405 EDMONDSON AVE DATE SIGNED 5/16/60							
ACTUAL SIGNATURE Cliff Ratliff Jr.				PHYSICIAN'S NAME (Type) CLIFF RATLIFE, JR. BALTIMORE 29 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/6/60		22c. NAME OF CEMETERY OR CREMATORY Lorraine	
22d. LOCATION (City, town, or county) (State) Baltimore							
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR MAY 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

MEDICAL CERTIFICATION

Baltimore

Cantonville

1 month

Baltimore

2320 Jefferson St.

Colon Alfred Luther Home

Paul L. Richardson (also brother)

May 3, 1940

male white

Sept. 12, 1934

Russia

Refugee

Stevenson

last brother

Mary

none

210-CV-755

Anastasia Richardson, 2320 Jefferson St.

Howard H. Hubbard - 107 Wilkens Ave.

Baltimore

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5543

CERTIFICATE OF DEATH

Reg. Dist. No.

05512

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b <u>55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1856 Edgewood Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Adam</u> Middle <u>Rauser</u> Last <u>Rauser</u>				4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-11-1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>		11. BIRTH PLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>GUSTAV</u>		14. MOTHER'S MAIDEN NAME <u>Monica</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>	
16. SOCIAL SECURITY NO. <u>219-32-0408</u>		17. INFORMANT <u>Eva Rauser</u>		18. Address <u>Home</u>		19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Recurrent</u> 260X DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Chronic Coronary Insufficiency and Auricular Fibrillation</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>5/21/60</u> , 19____, to <u>5/22/60</u> , 19____, that I last saw the deceased alive on <u>5/22/60</u> , 19____, and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <u>8358 Loch Raven Blvd, Towson Md</u> DATE SIGNED <u>5/23/60</u>	
23. ACTUAL SIGNATURE <u>Wm Conway</u>		24. PHYSICIAN'S NAME (Type) _____		25. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		26. DATE THEREOF <u>5-25-60</u>	
27. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		28. LOCATION (City, town, or county) <u>Balto</u> (State) <u>Md</u>		29. FUNERAL DIRECTOR'S SIGNATURE <u>Loch Raven Inc 2100 Eutaw Pl</u>		30. ADDRESS _____	
31. REC'D BY REGISTRAR <u>MAY 24 '60</u>		32. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		33. REGISTRAR'S SIGNATURE _____		34. REGISTRAR'S SIGNATURE _____	

05518

CERTIFICATE OF DEATH

2542

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

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5544
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05513

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle E. Last RENZ		4. DATE OF DEATH Month MAY Day 8 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-15-92
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY BREWERY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GERHARD RENZ		14. MOTHER'S MAIDEN NAME EMMA SCHUDENBERG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 217-16-7221	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS (SITE OF PRIMARY UNKNOWN) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from April 30 , 19 60 , to May 8 , 19 60 , that (X) (we) last saw the deceased alive on May 8 , 19 60 , and that death occurred 9:20 pm from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE SIGNED 5-9-60	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH Baltimore Md Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/60	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard Ruck Funeral Home-5305 Harford Rd		25a. REC'D BY REGISTRAR DATE MAY 11 '60	
ADDRESS Baltimore Md		25b. REGISTRAR'S SIGNATURE Arthur E. Hanes	

52113

CERTIFICATE OF DEATH

52114

NAME

NAME

RESIDENCE

DATE

DATE

1011 West 30th Street

VICTIM'S ADDRESS

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6108 Old Frederick Rd.</u>		d. STREET ADDRESS <u>6108 Old Frederick Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Estelle</u> Last <u>Ringgold</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry Ringgold</u>		Address <u>6108 Old Frederick Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> I Hour DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mitral Insufficiency</u> 4 Months 20 Days DUE TO (c) <u>Hypertensive Cardiac Disease</u> 2 Yrs. 4 Months 20 Days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 15th 1958</u> , to <u>May 24th 1960</u> , that I last saw the deceased alive on <u>May 24th 1960</u> , and that death occurred at <u>2.00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. F. Maloney, M.D.</u>		ADDRESS (Street, city or town, state) <u>57 Winters Lane</u>	
DATE SIGNED <u>May 24-60</u>			
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>		<u>Catonsville, 28. Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>5-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westview Mem. Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Johnson</u>		ADDRESS <u>1011-13 N. Arlington Ave</u>	
24a. REC'D BY REGISTRAR <u>MAY 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>James A. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b 16, Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dogwood Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle W. Last Ritter		4. DATE OF DEATH Month May Day 13 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1871
9. AGE (In years lost birthday) yrs. 89		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Daniels Mills	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas H Ritter		14. MOTHER'S MAIDEN NAME Racheal Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218.09.5776A	
17. INFORMANT Mrs. Truman Ritter		Address Dogwood Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Generalized Extremities DUE TO (c) Hypertension Cardiac Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-19-60 to 5-13-60 , that I last saw the deceased alive on 5-13-60 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4509 Liberty Hwy Md DATE SIGNED Thos H Ritter ACTUAL SIGNATURE Thos H Ritter M.D. 4509 Liberty Hwy Md PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/16/60	22c. NAME OF CEMETERY OR CREMATORY Lorraine	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stansbury		24a. REC'D BY REGISTRAR MAY 16 '60	
ADDRESS 6411 Windsor Mill Rd.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05516

5547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 53 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 Hilltop Road, Towson		d. STREET ADDRESS 21 Hilltop Road	
3. NAME OF DECEASED (Type or print) First Anna Middle Estelle Last Rosenberger		4. DATE OF DEATH Month May Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17th., 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 3 Days 17	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lyell		14. MOTHER'S MAIDEN NAME Anna S. Matteer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. John H. Rosenberger-21 Hilltop Road, Towson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Hypertensive Arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Renal Vascular Disease DUE TO (c) 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1948 to May 4, 1960 , that I last saw the deceased alive on April 4, 1960 and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd DATE SIGNED 5/4/60	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell		Towson Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-1960	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Belair Rd, Balto: Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc.		ADDRESS -1735 Harford Avenue, Balto:	
24a. REC'D BY REGISTRAR DATE MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

5547

DECEASED Name: Henry Bell Sex: Male Date of Birth: Jan. 17, 1880 Race: White Color: White Height: 5' 10" Weight: 150 Eyes: Blue Hair: Gray Occupation: None Usual Residence: 21 Hilltop Road, Towson Present Residence: 21 Hilltop Road, Towson Date of Death: Jan. 17, 1930 Place of Death: Home Cause of Death: Heart Disease Immediate Cause: Myocardial Infarction Underlying Cause: Coronary Arteriosclerosis Contributing Cause: None Duration of Illness: None Usual Occupation at Time of Death: None Name of Physician: Dr. J. H. H. Rosenberg Name of Hospital: None Name of Undertaker: None Name of Burial Place: None Name of Minister: None Name of Funeral Home: None Name of Cemetery: None Name of Interment: None Name of Burial Place: None Name of Minister: None Name of Funeral Home: None Name of Cemetery: None Name of Interment: None	
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21 HILLTOP ROAD, TOWSON

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MEDICAL CERTIFICATION

VR AIS (4)
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CERTIFICATE OF MARRIAGE

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[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05518

5540

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>42 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>325 N. Marlyh Ave</i>		d. STREET ADDRESS <i>325 N. Marlyh Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Stefan</i> Middle <i>Rothermel</i> Last <i>Rothermel</i>		4. DATE OF DEATH Month <i>5</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-21-1884</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bricklayer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Rothermel</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-7991</i>	
17. INFORMANT <i>Mrs. Jeannette Rothermel</i>		Address <i>325 No Marlyh Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic cardiac</i> DUE TO (c) <i>Vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prostatic Hypertrophy with retention</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>60</i> , to <i>May 24</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>May 24</i> , 19 <i>60</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. Baumgardner</i>		ADDRESS (Street, city or town, state) <i>Balto Md</i>	
PHYSICIAN'S NAME (Type) <i>M.D.</i>		DATE SIGNED <i>5/24/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-28-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Smith</i>		ADDRESS <i>7401 Belair Rd</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 26 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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05519

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Conv.Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary M. (Lena) Ruehl		4. DATE OF DEATH May 22/60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1875
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -----Noun		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wilhelmina Noone, 412 Overbrook Rd		Address Catonsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIOVASCULAR DISEASE DUE TO (c) CIRCULATORY COLLAPSE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1 19 57 to 5/22 19 60 , that (I) (we) last saw the deceased alive on 5/22 19 60 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John D. Shaw		22b. DATE SIGNED 5/24/60	
22c. PHYSICIAN'S NAME (Type) JOHN D. SHAW M.D.		22d. ADDRESS 5504 EDMONDSON AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 25/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Balto. 29, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR MAY 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

Ms. Baltimore
Catonville 2 yrs
Shady Brook Conv. Home
May 22/60
Mary M. (Dora) Russell
Female White XX
March 11, 1878 88
H.W. Own Home
Germany
USA
Unknown

Catonville
Mrs. Wilhelmina Moore, 413 Overbrook Rd

Burial May 22/60
Burial 2 P.M. 4101 Woodson Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5551

CERTIFICATE OF DEATH

05520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lena Middle Last Sacks				4. DATE OF DEATH Month May Day 31 Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? Russia							
13. FATHER'S NAME Unknown Samuel Lipsitz				14. MOTHER'S MAIDEN NAME Unknown Sarah ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 5, 1960 , to May 31, 1960 , that I last saw the deceased alive on May 31, 1960 , and that death occurred at 2:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 5-31-60							
ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 5-31-60							
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Kovna Cong		22d. LOCATION (City, town, or county) (State) Rosedale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Rd.				24a. REC'D BY REGISTRAR JUN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>10. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>11. SIGNATURE OF WITNESS [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	

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 5552
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

05521

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3836 Bon View Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ARTHUR R. ST. CLAIR First Middle Last				4. DATE OF DEATH Month May Day 29 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1923 9. AGE (In years lost birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dye Maker		10b. KIND OF BUSINESS OR INDUSTRY Dye Company		11. BIRTHPLACE (State or foreign country) Morgantown, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur R. St. Clair, Sr.				14. MOTHER'S MAIDEN NAME Sarah E. Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 218-14-7506		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Balto, 18, Md. Ft. Address Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CHRONIC GLOMERULONEPHRITIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 mos. 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 11 11:05 to May 29 , 19 60 , that X (we) last saw the deceased alive on May 29 , 19 60 and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moses Lichtig 22c. PHYSICIAN'S NAME (Type) MOSES LICHTIG, M.D.				22b. DATE SIGNED 5/30/60 22d. ADDRESS VAH, Baltimore 18, Md. Ft. Howard Div.		22e. DATE SIGNED 5/30/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-60		23c. NAME OF CEMETERY OR CREMATORY Lawn Wood Cemetery		23d. LOCATION (City, town, or county) (State) Morgantown, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Baltimore, Maryland ADDRESS				25a. REC'D BY REGISTRAR DATE JUN 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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CERTIFICATE OF DEATH

05522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosemont</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosemont</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2819 Pennsylvania Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Latherine</u> First Middle Last <u>Schmuck</u>		4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/1886</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank G. Untermyer</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Mueller</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Teresa C. Thompson</u> <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO <u>2.60X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis, left</u> DUE TO <u>Diabetes Mellitus</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/13</u> , 19 <u>53</u> , to <u>5/24</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>5/23</u> , 19 <u>60</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Unlook Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>1227 Waverly Blvd Baltimore 30th 5/24/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN P. UNLOOK JR.</u>		DATE SIGNED <u>5/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> ADDRESS <u>Rollins St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: *John A. Smith*
2. Sex: *Male*
3. Age: *65*
4. Date of birth: *Jan 15 1880*
5. Date of death: *Dec 10 1945*
6. Place of death: *Home*
7. Cause of death: *Heart failure*
8. Signature of physician: *J. H. Jones*
9. Signature of registrar: *W. B. Brown*
10. Signature of informant: *M. A. Smith*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05523

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE CALIFORNIA b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE	c. LENGTH OF STAY IN 1b 7 YRS-5 MO	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLY WOOD 43X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 1338 1/2 MILLER DRIVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH SCHNEIDER		4. DATE OF DEATH Month Day Year MAY 19 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 10, 1870
9. AGE (In years lost birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME EDWARD KELLER	
14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Frank R. Smith Jr. - Cockeysville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-Sclerotic Cardiovascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-12 19 53 , to 5-18 19 60 , that (I) (we) last saw the deceased alive on 5-18 19 60 , and that death occurred at 11:55 AM , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 5/19/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-21-60	23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery
23d. LOCATION (City, town, or county) (State) Baltimore		24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street	
25a. REC'D BY REGISTRAR DATE MAY 24 '60		25b. REGISTRAR'S SIGNATURE Caroline S. Thomas	

05557

CERTIFICATE OF DEATH

05557



EDWARD KELLEY
HUSBAND OF
MARGARET KELLEY
BORN MAY 19 1885
DIED MAY 19 1965
AGE 80 YEARS
CAUSE OF DEATH
HEART DISEASE
PLACE OF DEATH
HOSPITAL

EDWARD KELLEY
HUSBAND OF
MARGARET KELLEY
BORN MAY 19 1885
DIED MAY 19 1965
AGE 80 YEARS
CAUSE OF DEATH
HEART DISEASE
PLACE OF DEATH
HOSPITAL

5555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3101.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		d. STREET ADDRESS <u>4314 Reisterstown Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Seiden</u> Last		4. DATE OF DEATH Month <u>5</u> - Day <u>19</u> - Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry</u>		14. MOTHER'S MAIDEN NAME <u>Mollie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Harry Seiden - 3907 Grantley Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Arteriosclerotic C. V. Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 20</u> , 19 <u>60</u> , to <u>May 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>60</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manuel Levin</u> M.D.		ADDRESS (Street, city or town, state) <u>4818 Reisterstown Rd</u> DATE SIGNED <u>5/19/60</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, M.D.</u>		<u>Balt. - 15 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-20-60</u>	<u>Rosedale</u>	<u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Levin Inc</u> ADDRESS <u>2100 Eaton Pl</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5906 Cecil Ave				d. STREET ADDRESS 1 5906 Cecil Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Phoebe Middle Alice Last Shaver				4. DATE OF DEATH Month May Day 31 Year 1960			
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 18 86		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 7 Days 14	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Neil Mullins				14. MOTHER'S MAIDEN NAME Racheal Mullins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Hilton Church 5906 Cecil Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Cardio vascular heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> May 31, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/3/60		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE JT STANSBURY BALTO. MD				24a. REC'D BY REGISTRAR JUN 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO DESTROY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one copy is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05526

Reg. Dist. No.

5406

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin D. Sherfey</u>		4. DATE OF DEATH <u>May 20, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Mt. Saint Agnes</u>	
13. BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Benjamin F. Sherfey</u>		16. MOTHER'S MAIDEN NAME <u>Lavina L. Eyler</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.11</u>		18. SOCIAL SECURITY NO. <u>212-14-1968A</u>	
19. INFORMANT <u>Reisterstown, Md.</u>		20. Mr. Charles R. Bosley, Glen Falls Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery Disease</u> (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>None</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 23, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westminister Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminister, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. H. Newell, 1100 Reisterstown Rd.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Huns</u>	
ADDRESS <u>Pikesville 8</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	
DATE <u>MAY 26 '60</u>			

105536

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2508

FOR STATE
HEALTH DEPT.
M

1

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. Includes checkboxes for various conditions and a large area for the examiner's signature and notes.

Vertical text on the right margin, likely a filing or processing stamp.

5395

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn. b. COUNTY Delmont	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 343 Old Trail		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Robert Jackson Shields		4. DATE OF DEATH 5-5-60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		11. BIRTHPLACE (State or foreign country) Penn.	
10b. KIND OF BUSINESS OR INDUSTRY public schools		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME Samuel Shields		14. MOTHER'S MAIDEN NAME Mary Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Hubert I. Snyder, 343 Old Trail, Balto. 12,	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO CORONARY HEART DISEASE (c) YEARS		INTERVAL BETWEEN ONSET AND DEATH 25 MINUTES 30 MINUTES YEARS
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 5 , 19 60 , to MAY 5 , 19 60 , that I last saw the deceased alive on MAY 5 , 19 60 , and that death occurred at 5:40 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 25 W. Pa. Ave	
ACTUAL SIGNATURE Donald L. Somerville		DATE SIGNED 5/6/60	
PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE		Lawson & Md	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-60.		22c. NAME OF CEMETERY OR CREMATORY Delmont Presbyterian		22d. LOCATION (City, town, or county) (State) Delmont, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Pages 1 and 2 should be filled in by the funeral director. Pages 3 and 4 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6335

Tenn.

Baltimore

Belmont

4 days

Baltimore 12,

30 E. Pittsburgh St.

343 Old Trail

7-5-50

Robert Jackson Shield

90

3-9-1870

white

male

U.S.A.

Tenn.

public schools

Sept.

Mary Jackson

Samuel Shield

Robert I. Snyder, 343 Old Trail, Baltimore, Md.

Mary Jackson

Samuel Shield

Robert I. Snyder

Belmont, Tenn.

Belmont, Tenn.

Belmont, Tenn.

Belmont, Tenn.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5557

CERTIFICATE OF DEATH

Reg. Dist. No.

05528

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 185		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mattie Middle M. Last Shipley		4. DATE OF DEATH Month May Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Tetlow		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Earl Shipley		Address Box 185 Kingsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1960 , to May 24, 1960 , and that I last saw the deceased alive on May 22, 1960 , and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9660 Belair Road DATE SIGNED May 25, 1960			
ACTUAL SIGNATURE Theodore E. Evans M.D.		DATE SIGNED May 25, 1960	
PHYSICIAN'S NAME (Type) Theodore E. Evans			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1960	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Lutheran		22d. LOCATION (City, town, or county) (State) Perry Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home		24a. REC'D BY REGISTRAR DATE MAY 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

5553

NAME OF DECEASED
KIRK, J. L.

AGE
40

SEX
Male

DATE OF DEATH
April 1, 1938

PLACE OF DEATH
Home

Cause of Death
Heart Disease

Signature of Physician
J. L. Kirk

Signature of Registrar
J. L. Kirk

Signature of Coroner
J. L. Kirk

Signature of Burial Officer
J. L. Kirk

Signature of Minister
J. L. Kirk

Signature of Undertaker
J. L. Kirk

Signature of Funeral Home
J. L. Kirk

Signature of Cemetery
J. L. Kirk

Signature of Burial
J. L. Kirk

Signature of Interment
J. L. Kirk

Signature of Burial
J. L. Kirk

Signature of Interment
J. L. Kirk

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leonard J. Ruck, Inc.	5305 Harford Rd.	DATE MAY 31 '60	<i>Arthur L. Hanna</i>

VR AIS (4)
1SM 9/59

2528

CERTIFICATE OF DEATH

05229



DECEASED

DATE

AGE

SEX

CAUSE

PLACE AND DATE OF DEATH

DATE

PLACE

SEX

AGE

CAUSE

DATE

PLACE

DATE

AGE

SEX

PLACE AND DATE OF DEATH

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PLACE AND DATE OF DEATH

DATE

SEX

PLACE AND DATE OF DEATH

5559

CERTIFICATE OF DEATH

05530

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Katherine Post Nursing Home</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>937 Milford Mill Road</u>	
3. NAME OF DECEASED (Type or print) <u>Carrie Alice Smith</u> First Middle Last 4. DATE OF DEATH <u>May 1 1960</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 3 1867</u> 9. AGE (In years last birthday) <u>92</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bates</u> 14. MOTHER'S MAIDEN NAME <u>Margaret</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>420.0</u> 17. INFORMANT <u>J. Harold Smith</u> Address <u>937 Milford Mill Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> DUE TO (c) <u>420.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>slow years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Oct 19 1958</u> to <u>1 May 1960</u> that I last saw the deceased alive on <u>11 Apr 1960</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>802 Reisterstown Rd Pikesville 8 Md.</u> DATE SIGNED <u>1 May 60</u>	
ACTUAL SIGNATURE <u>Paul H Royse</u> PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>May 4-1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arundel Ridge</u> 22d. LOCATION (City, town, or county) (State) <u>Pikesville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Horace F. Rungel</u> ADDRESS <u>3631 Falls Road</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hines</u> DATE <u>MAY 4 '60</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

5560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Spurrer Last Spurrer				4. DATE OF DEATH Month May Day 5 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 16, 1883	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-09-49800			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from April 30, 1960 to May 5, 1960 that I last saw the deceased alive on May 5, 1960 and that death occurred at 3:30 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Bruno Radauskas M.D. SPRING GROVE STATE HOSPITAL 5-5-60							
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 5-9-60							
22c. NAME OF CEMETERY OR CREMATORY WESTERN							
22d. LOCATION (City, town, or county) (State) BALTIMORE, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Francis W. Miller 2101 Frederick Ave							
ADDRESS 2101 Frederick Ave							
24a. REC'D BY REGISTRAR DATE MAY 9 '60							
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b
<u>52</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>210 March Ave.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Willi</u> am Middle <u>Henry</u> Last <u>Stewart</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>29</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 8/1908</u> | | 9. AGE (In years last birthday)
<u>52</u> | IF UNDER 1 YEAR
Months <u>52</u> Days <u>19</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Labour</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Catonsville Md</u> | | 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Arthur Stewart</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Josephine Hook</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>210-05-4199</u> | | 17. INFORMANT
<u>Mrs Margaret King</u> Address <u>210 March Ave</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary heart disease (thrombosis)</u>
<u>420.1</u> DUE TO <u>Cardio vascular disease</u>
Conditions, if any, which gave rise to immediate cause (b) _____
(c) _____
DUE TO _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<u>Geo. S. M. Kieffer</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
<u>Geo. S. M. Kieffer M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 29, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>6-1-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Western Star Cem</u> | | 22d. LOCATION (City, town, or county) _____ (State) <u>Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Mrs. Frances H. Henning</u> | | | | ADDRESS
<u>578 W. Biddle St.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JUN 2 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5562

05533

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rosedale | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 7710 Philadelphia Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Daisy L Stuhr | | 4. DATE OF DEATH May 3/60 | |
| 5. SEX female | | 6. COLOR OR RACE white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 11 1890 | |
| 9. AGE (In years lost birthday) 69 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Penna | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Richard Morgans | | 14. MOTHER'S MAIDEN NAME Mary Morgan | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Address Albert Stuhr 7710 Phila Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIO SCLEROSIS SYST.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY 1 , 19 60 , to MAY 3 , 19 60 , that I last saw the deceased alive on MAY 1 , 19 60 , and that death occurred at 5 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Emmett P Davis | | ADDRESS (Street, city or town, state) 5317 BELAIR RD DATE SIGNED 5/5/60 | |
| PHYSICIAN'S NAME (Type) EMMETT P DAVIS | | BALTIMORE 6, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF May 6/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge | | 22d. LOCATION (City, town, or county) (State) Howard County | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road | | 24a. REC'D BY REGISTRAR MAY 11 '60 24b. REGISTRAR'S SIGNATURE Orlino S. Knaus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5562

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *1930-01-15*

5. Date of death: *1975-03-10*

6. Time of death: *10:30 AM*

7. Place of death: *Home*

8. Cause of death: *Heart Disease*

9. Signature of physician: *[Signature]*

10. Signature of registrar: *[Signature]*

11. Date of registration: *1975-03-15*

12. Place of registration: *City Hall*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05534

5398

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>3</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>DUNDALK</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE 23</u> | | 3V01.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>VULCAN HART CO - OLD North Point Rd</u> | | | | d. STREET ADDRESS
<u>1337 RAMSAY St</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>VINCENT</u> Last <u>SUETA</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>20</u> Year <u>1960</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>31 May 1906</u> | | 9. AGE (In years last birthday)
<u>53</u> yrs. | IF UNDER 1 YEAR
Months <u>53</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Spot WELDER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Stove mfg</u> | | 11. BIRTHPLACE (State or foreign country)
<u>PENNA</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>VINCENT SUETA</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Josephine Budrevicz</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>yes WW2</u> | | 16. SOCIAL SECURITY NO.
<u>707-05-0008</u> | | 17. INFORMANT
<u>VICTOR W. SUETA 749 E. 37th St BALTO 18 Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u>
420-1 DUE TO (b) <u>Hypertensive Cardiovascular Dis.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>
<u>3 yrs</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<u>Jack C Collins</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>BALTO. 22</u> DATE SIGNED <u>5-20-60</u> | | | |
| EXAMINER'S NAME (Type)
<u>JACK C COLLINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>24 May 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>BALTO NATIONAL Cem</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTO Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Not a Director</u> | | | | ADDRESS
<u>Pratt Stricker St</u> | | 24a. REC'D BY REGISTRAR
<u>MAY 23 '60</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hanna</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08483

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH RECORD 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|------------------------------|--|----------------------------|--|
| <p>NAME OF DECEASED</p> | | <p>DATE OF BIRTH</p> | |
| <p>SEX</p> | | <p>AGE</p> | |
| <p>DATE OF DEATH</p> | | <p>TIME OF DEATH</p> | |
| <p>PLACE OF DEATH</p> | | <p>CAUSE OF DEATH</p> | |
| <p>DATE OF EXAMINATION</p> | | <p>TIME OF EXAMINATION</p> | |
| <p>NAME OF EXAMINER</p> | | <p>ADDRESS OF EXAMINER</p> | |
| <p>SIGNATURE OF EXAMINER</p> | | <p>DATE OF SIGNATURE</p> | |
| <p>NAME OF DECEASED</p> | | <p>DATE OF BIRTH</p> | |
| <p>SEX</p> | | <p>AGE</p> | |
| <p>DATE OF DEATH</p> | | <p>TIME OF DEATH</p> | |
| <p>PLACE OF DEATH</p> | | <p>CAUSE OF DEATH</p> | |
| <p>DATE OF EXAMINATION</p> | | <p>TIME OF EXAMINATION</p> | |
| <p>NAME OF EXAMINER</p> | | <p>ADDRESS OF EXAMINER</p> | |
| <p>SIGNATURE OF EXAMINER</p> | | <p>DATE OF SIGNATURE</p> | |

1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5563

05535

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 40, Allender Road | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville
d. STREET ADDRESS Route 40, Allender Road | | | |
| 3. NAME OF DECEASED
(Type or print) JOHN William SWEENEY | | | | 4. DATE OF DEATH
Month May Day 16 Year 19 60 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-2-1923 | |
| 9. AGE (In years last birthday) 36 yrs. | | | | IF UNDER 1 YEAR
Months 36 Days 36 | | IF UNDER 24 HRS.
Hours 36 Min. 36 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Analyst | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Patrick J. Sweeney | | | |
| 14. MOTHER'S MAIDEN NAME Sarah A. Brogan | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) WW 2 | | | |
| 16. SOCIAL SECURITY NO. WW 2 | | | | 17. INFORMANT Marjorie A. Sweeney Address same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO 42 0.0
Conditions, if any, which gave rise to immediate cause (b)
(c) 42 0.0 DUE TO 42 0.0
(e), stating the underlying cause last. (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE W. Bradley King, Jr., M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 5/17/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 5-19-60 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or country) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Rd. | | | | 24a. REC'D BY REGISTRAR MAY 19 60 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

MEDICAL CERTIFICATION

(M)

(1)

STATE OF NEW YORK
COUNTY OF ALBANY
JAMES H. HARRIS
JAMES H. HARRIS
JAMES H. HARRIS

ALBANY, N.Y.
JAMES H. HARRIS
JAMES H. HARRIS
JAMES H. HARRIS

1-1-1923
JAMES H. HARRIS
JAMES H. HARRIS
JAMES H. HARRIS

JAMES H. HARRIS
JAMES H. HARRIS
JAMES H. HARRIS

JAMES H. HARRIS
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JAMES H. HARRIS
JAMES H. HARRIS
JAMES H. HARRIS

JAMES H. HARRIS
JAMES H. HARRIS
JAMES H. HARRIS

5564

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore County</i>
<i>Catonville</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>✓</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Baltimore Md.</i> | | c. LENGTH OF STAY IN 1b
<i>3001.4</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Baltimore</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Summit Nursing Home</i>
<i>Smithwood Ave.</i> | | | | d. STREET ADDRESS
<i>907 Fell St.</i> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Peter</i> Middle <i>Szymanski</i> Last <i>Szymanski</i> | | | | 4. DATE OF DEATH
Month <i>5</i> - Day <i>10</i> - Year <i>1960</i> | | | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<i>1896</i>
<i>5/12/1896</i> | 9. AGE (In years last birthday)
<i>63</i> yrs. | IF UNDER 1 YEAR
Months <i>63</i> Days <i>63</i> Hours <i>63</i> Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>John Szymanski</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Michalina</i>
<i>unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<i>100-1-10000</i> | | INFORMANT
Address
<i>Mary Szymanski 907 Fell St</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>527.1</i> DUE TO <i>Chronic Brain Syndrome associated with Arterio Sclerosis. Arteriosclerotic Heart Disease. senile Emphysema</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month <i>July</i> Day <i>1958</i> Year <i>5/10/60</i>
Hour <i>1000</i> a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>5/9/60</i> to <i>5/10/60</i> , that I last saw the deceased alive on <i>5/9/60</i> , 19 <i>60</i> , and that death occurred at <i>1000</i> P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<i>W.E. McGroth</i> | | M.D.
<i>W.E. McGroth</i> | | ADDRESS (Street, city or town, state)
<i>1303 Frederick Rd Catonsville 28md</i> | | DATE SIGNED
<i>5/11/60</i> | |
| PHYSICIAN'S NAME (Type)
<i>W.E. McGroth</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial May 14, 1960</i> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
<i>St Stanislaus</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Baltimore</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Fred W Ozazewski</i> | | | | ADDRESS
<i>1930 Eastern Ave</i> | | 24a. REC'D BY REGISTRAR
DATE <i>MAY 12 '60</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kline</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05230

CERTIFICATE OF DEATH

1914

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1
FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05537

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 1b
53 | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dundalk | | d. STREET ADDRESS
8000 Mid-Haven Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8000 Mid-Haven Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
BEATRICE | | First Middle Last
THOMAS | | 4. DATE OF DEATH
Month Day Year
May 30 19 60 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 22, 1925 | 9. AGE (In years last birthday)
34 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Harlan County, Kentucky | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Sheppard | | | | 14. MOTHER'S MAIDEN NAME
Lizzie Hemsley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Hemsley Funeral Home, Harlan, Kentucky | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Stab Wound of Left Chest.
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }
DUE TO
(b)
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Stabbed during altercation. | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
May 30 19 60 | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Dundalk Baltimore Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5/31/60 | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Petty | | M.D. Charles S. Petty, M.D. | | | | | |
| EXAMINER'S NAME (Type)
Charles S. Petty, M.D. | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 22b. DATE THEREOF
6-1-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Stanfill Cemetery | | 22d. LOCATION (City, town, or country) (State)
Harlan County, Kentucky | |
| 23. FUNERAL DIRECTOR
ADDRESS
William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR
DATE JUN 1 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |



United Cook, Inc., 1215 E. Paul Street

June 1, 1960

Harlan County, Kentucky

Shanell's Cemetery

6-1-60

RECEIVED

Charles A. Porter, M.D.

5/31/60

x

x

x

x

Stained during transportation.

x

Step found on left coast.

Hershey Funeral Home, Harlan, Kentucky

Missie Hershey

Housesville

John Shepero

Harlan County, Kentucky

U.S.A.

July 22, 1955

White

male

x

T. H. Hays

May

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6000 N. - Haven Road

6000 N. - Haven Road

Dundalk

Dundalk

Baltimore

Baltimore

05547

3397

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Items 8, 9 FilmG268 8-3-60 et

CERTIFICATE OF DEATH

05538

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Garrison</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Garrison</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Valley Road</u> | | | | d. STREET ADDRESS
<u>Valley Road</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>John</u> Middle <u>G.</u> Last <u>Thomas</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>31</u> Year <u>1960</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-3-1893</u> 1893 | | 9. AGE (In years last birthday)
<u>76</u> yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Banking</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> |
| 13. FATHER'S NAME
<u>John Marshall Thomas</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Anne Campbell Gregg</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW 1</u> | | 16. SOCIAL SECURITY NO.
<u>215-18-2061</u> | | 17. INFORMANT
<u>A Mrs. J.T. Barthel</u> Address <u>Above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-Vascular Renal disease</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u>
DUE TO (c) <u>uremic coma</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>18 months</u>
<u>5 years</u>
<u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>60</u> , to <u>May 31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>60</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Palmer F.C. Williams</u> M.D. | | | | ADDRESS (Street, city or town, state)
<u>1725 Ruststown Rd. - Pikesville 8. Md.</u> | | | |
| DATE SIGNED
<u>June 1. 60</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>6-2-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Thomas'</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Garrison Forest Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>H.W. Jenkins & Sons Co.</u> ADDRESS
<u>4905 York Rd. Balto. 12, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>JUN 2 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hancock</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #3-FilmG262-5/10/60-mmb

5566

CERTIFICATE OF DEATH

05539

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | c. LENGTH OF STAY IN lb <u>45 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6601 Kenwood Ave.</u> | | | | d. STREET ADDRESS <u>6601 Kenwood Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>(JACK) Hersey F. Thompson</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 3 1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-25-1899</u> | |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. R.R.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Thomas Thompson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Serra (Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | |
| INFORMANT Address <u>Rose E. Thompson 6601 Kenwood Ave.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u>
422.1 DUE TO <u>Arteriosclerotic Cardio Vascular Dis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>2 yrs</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputated Rt leg</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>May 3</u> , 19 <u>60</u> that I last saw the deceased alive on <u>May 3</u> , 19 <u>60</u> and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>WMB Baumgardner M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Balto 6 Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>5/4/60</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>5-6-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Balto, Nat'l. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Fam'l Home</u> ADDRESS <u>7401 Belair Rd.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 6 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03750

CERTIFICATE OF DEATH

2588

CO. 12

Township

County

State

12-25-1914

Thompson

Thompson

Wm. E. Thompson

Green

Western

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| <div>Items 18-21 Film 263 3-21-60</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>5540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05540</div> | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cockeysville | | | c. LENGTH OF STAY IN 1b
life | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Texas Cockeysville | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
York Rd. | | | | | d. STREET ADDRESS
York Rd. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
THOMAS Lewis THOMPSON | | | | | 4. DATE OF DEATH
Month May Day 13 Year 1960 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3-20-58 | | 9. AGE (In years last birthday) 2 yrs. | | |
| | | | | | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Thomas A. Thompson | | | | | 14. MOTHER'S MAIDEN NAME
Gladys Cornett | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Thomas A. Thompson | | Address
above | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PENDING Hemorrhagic Bronchopneumonia
881.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infection, Bronchiectasis of middle lobe of right lung
(c) lobe of right lung | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Ingested and aspirated lighter fluid | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
12:00 p.m. 5/13 1960 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town)
Texas | | (County) Balto. (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Will. J. [Signature]</i> | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> May 13, 1960 DATE SIGNED | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 22b. DATE THEREOF
5-14-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Prospect Hill | | 22d. LOCATION (City, town, or country) (State)
Towson 4, Md. | | | |
| 23. FUNERAL DIRECTOR
Brooks Funeral Service, Towson 4, Md. | | | | | ADDRESS | | 24a. REC'D BY REGISTRAR
DATE MAY 18 '60 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. [Signature]</i> | |



Cookesville

York Co.

late

York Co.

Cookesville

Thomas Taylor

3-22-58

2

none

Maryland

U.S.A.

Thomas A. Thompson

Gladys

Connecticut

none

Thomas A. Thompson above

Burial

3-4-60

Prospect Hill

Township, Md.

Brooks Funeral Service, Towson, Md.

May 18, 1960

5568

CERTIFICATE OF DEATH

05541

Reg. Dist. No.

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>1mtn28dys</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Seat Pleasant, Md.</u> | | <u>1629.2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>SPRING GROVE STATE HOSPITAL</u> | | | | d. STREET ADDRESS
<u>213 Addison Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Joseph</u> Middle <u>C.</u> Last <u>Tippett</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>2</u> Year <u>1960</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 25, 1880</u> | 9. AGE (In years lost birthday) yrs.
<u>80</u> | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired truck-farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>John Tippett</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>218-10-0364</u> | | | |
| INFORMANT
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u> </u> <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 4, 1960</u> to <u>May 2, 1960</u> , that I last saw the deceased alive on <u>May 2, 1960</u> , and that death occurred at <u>6:00a</u> AM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Aristides Simopoulos</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>5-2-60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Aristides Simopoulos, M. D.</u> | | | | <u>Catonsville 28, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5-5-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>F. Gasch's Sons</u> | | | | ADDRESS
<u>Hyattsville, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 6 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Claudia S. Frank</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 2 hours after death. The low requires that the death certificate be executed within 2 hours after death. The low requires that the death certificate be executed within 2 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05501

CERTIFICATE OF DEATH

5568

ADAM J. JAMES

MALE

WHITE

1910

1910

1910

1910

1910

1910

1910

1910

1910

**FOR STATE
HEALTH DEPT.**

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [redacted] delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

CO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Item 18 Film 264 6-10-60
 5 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 5569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05542

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN Ib
1 yr. 2 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
52 Rural | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Eudowood Sanatorium | | d. STREET ADDRESS
1 221 Preston Ct., | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
MARY | | First Middle Last
E. Wagner TODD | | 4. DATE OF DEATH
Month Day Year
May 20 1960 | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
1900 | | 9. AGE (In years last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months Days
59 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Charles Ford | | 14. MOTHER'S MAIDEN NAME
Estella James | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
212-20-8733 | | 17. INFORMANT
Mrs Robert Rothschild, 560 Graystone Rd., Ambler Pa. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary emphysema, bilateral, marked
527.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
5/20/60 | | INTERVAL BETWEEN ONSET AND DEATH | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
5/20/60 | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
5/20/60 | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
5/20/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 23/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Springhill Cemetery | |
| 22d. LOCATION (City, town, or country) (State)
Easton Md. | | 23. FUNERAL DIRECTOR
Witzke Fun. Dir. 4101 Edmondson Ave., #29, Md. | | 24a. REC'D BY REGISTRAR
May 24 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | 24c. NAME OF CEMETERY OR CREMATORY
Springhill Cemetery | | 24d. LOCATION (City, town, or country) (State)
Easton Md. | |

ON FILE
MAY 1960



Burial May 23/60 Springhill Cemetery Boston MA.

Witake Tom. Dir. 101 Hammond Ave. 22, MA.

MAY 24 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5570

CERTIFICATE OF DEATH

05543

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Graffite</i> | | c. LENGTH OF STAY IN 1b <i>50 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>BLANCHÉ D. TRAMMELL</i> | | 4. DATE OF DEATH <i>MAY 27 1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 28, 1884</i> |
| 9. AGE (In years last birthday) <i>76</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>England</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Frank Gardner</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Mr. John H. Trammell - Graffite, Md.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i>
<i>422.1</i> DUE TO (b) <i>Arteriosclerosis</i>
Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) <i>—</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>May 29, 1960</i> to <i>May 27, 1960</i> , that (I) (we) last saw the deceased alive on <i>May 26, 1960</i> , and that death occurred at <i>5:00 P.</i> M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Wm. E. Martin</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <i>Wm. E. MARTIN</i> | | 22d. ADDRESS <i>RANDOLPHS TOWN, MD.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>5-30-60</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Graffite Presbyterian</i> | | 23d. LOCATION (City, town, or county) (State) <i>Graffite Baltimore, Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i> | | 25a. REC'D BY REGISTRAR <i>JUN 1 '60</i> | |
| ADDRESS <i>Chesapeake, Md.</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Haight</i> | |

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

2570

1050



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5571

CERTIFICATE OF DEATH

Reg. Dist. No. 05544

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | c. LENGTH OF STAY IN 1b
<u>3001.4</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Holly Hill Manor</u> | | | | d. STREET ADDRESS
<u>3213 The Alameda</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Adelia</u> Middle <u>Trostle</u> Last <u>Trostle</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>8</u> Year <u>19 60</u> | | | |
| 5. SEX
<u>female</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 5, 1884</u> | |
| 9. AGE (In years lost birthday)
<u>76</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Baltimore, Maryland</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Charles Jording</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elise Andra</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u> </u> | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Hypertensive-arteriosclerotic Cardio-Vascular Disease</u>
DUE TO
(c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 weeks</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | 20c. TIME OF INJURY
Month <u> </u> Day <u> </u> Year <u>19</u>
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | | |
| 20f. (City or town)
<u> </u> | | | | (County) <u> </u> (State) <u> </u> | | | |
| 21. I certify that I attended the deceased from <u>Mar. 20</u> , 19 <u>60</u> , to <u>May 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>60</u> , and that death occurred at <u>11:37 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Loy M. Zimmerman</u> | | | | ADDRESS (Street, city or town, state)
<u>3202 Hargford Rd Baltimore - 18, Md.</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Loy M. Zimmerman M.D.</u> | | | | DATE SIGNED
<u>5/9/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>5/11/60</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Western Cemetery</u> | | | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 10 '60</u> | | | |
| ADDRESS
<u>5305 Hargford Road #14</u> | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kneass</u> | | | |

MEDICAL CERTIFICATION

5371

CERTIFICATE OF DEATH

5371

Blank form with faint lines and text, including a large circular stamp on the right side.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5572

CERTIFICATE OF DEATH

05545

Reg. Dist. No.

Items 1+4 - Phone call 6/5/60 - m/s
Items 8, 14 Film G264 6-9-60 et

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1408 Spring Avenue</u> | | d. STREET ADDRESS <u>1408 Spring Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Ella Clara Turner</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>Female</u> | | 6. COLOR OF RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1884</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Hyman</u> | | 14. MOTHER'S MAIDEN NAME <u>Ella Hiner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mr Walter Turner</u> | | Address <u>1408 Spring</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of the breast operated</u>
DUE TO (b) <u>Pl of Dr Goodman</u>
DUE TO (c) <u>3400 E Baltimore St, Balto</u>
INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2</u> P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Dr J Geldrich</u> | | M.D. | |
| PHYSICIAN'S NAME (Type) <u>Dr. John Geldrich</u> | | <u>8019 Philadelphia Rd.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal Jan 3/60</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Richland Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Johnstown Pa</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Home</u> | | 24a. RECEIVED BY REGISTRAR <u>JUN 2 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Home</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3120

556



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5573 Item 230, Film G202 5/16/60 iwk
 CERTIFICATE OF DEATH
 05546

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | c. LENGTH OF STAY IN 1b
1 Day | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
52 Baltimore (28) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | d. STREET ADDRESS
809 Edmondson Avenue | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
EDWARD S VAETH | | 4. DATE OF DEATH Month Day Year
May 8 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 15, 1896 |
| 9. AGE (In years last birthday)
63 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
8 19 60 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Automobiles | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
George F. Vaeth | |
| 14. MOTHER'S MAIDEN NAME
Sophia Nengle | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW I | |
| 16. SOCIAL SECURITY NO.
215-10-4873 | | 17. INFORMANT Address
Clin. Rec., VAH, Balto. 18, Md. Ft. Howard Division | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EMPHYEMA, LEFT LUNG
518X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) BRONCHOPNEUMONIA
XXETH
(c) SPLENITIS | | | INTERVAL BETWEEN ONSET AND DEATH
3 DAYS
3 DAYS
UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (if this hospital) attended the deceased from May 7 1960 to May 8 1960 that (he) (we) last saw the deceased alive on May 8 1960 , and that death occurred at 9:40 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John D. Talbert, M.D. | | 22b. DATE
5/9/60 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M.D. | | 22d. ADDRESS
VAH, BALTO. 18, MD. FORT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
May 12, 1960 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery Baltimore Maryland | 23d. LOCATION (City, town, or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Fahey & Sons, 1318 Light St. Balto. Md. | | 25a. REC'D BY REGISTRAR
MAY 11 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Clifford S. K... | | | |

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G263 5/26/60 iwk

5574

CERTIFICATE OF DEATH

05547
Reg. Dist. No.

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH: Rosewood State Training School
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore 3 vol. 4 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills, Maryland | | c. LENGTH OF STAY IN 1b
1 1/2 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Rosewood State Training School | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Carrie Middle Valenski Last Valenski | | 4. DATE OF DEATH
Month 5 Day 18 Year 19 60 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/11/38 |
| 9. AGE (In years lost birthday)
71 yrs. | | 10. IF UNDER 1 YEAR
Months 71 Days 18 Hours 19 Min. 60 | 11. IF UNDER 24 HRS.
Months 71 Days 18 Hours 19 Min. 60 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
? | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
--- | |
| 17. INFORMANT
Spring Grove and Rosewood Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
4-20-1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis, generalized
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Imbecile - etiology undetermined - birth. | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH
5-minutes | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/1/58 , 19____, to 5/18/60 , 19____, that I last saw the deceased alive on 5/18/60 , 19____, and that death occurred at 8:00a M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Rosewood Training School DATE SIGNED 5/18/60 | | | |
| ACTUAL SIGNATURE Harry G. Butler M.D. | | PHYSICIAN'S NAME (Type) Harry G. Butler, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF May 17 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Woods Memorial Park | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frank A. Newell, Pikesville, Md. | | 24a. REC'D BY REGISTRAR
MAY 18 1960 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Harris | | | |

10/1/77

STATEMENT OF WORK

10/1/77



1. The purpose of this statement is to define the work to be performed by the contractor under the contract.

2. The work to be performed is the design, development, and testing of a computer program to process and analyze data from a survey of the health status of the population of the United States.

3. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.

4. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.

5. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.

6. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.

7. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.

8. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.

9. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.

10. The contractor is to provide a detailed description of the work to be performed, including a schedule of work, a list of personnel to be assigned to the work, and a list of resources to be used.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

2

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------|--|-------------------------------------------------------------------|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 5576 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point
c. LENGTH OF STAY IN 1b
7406 Bay Front Road
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
7406 Bay Front Road | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point
d. STREET ADDRESS 7406 Bay Front Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
ERNEST William WADDELL | | | | | 4. DATE OF DEATH
May 27 1960 | | | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 19, 1913 | | 9. AGE (In years and birthday) 46 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel Co | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | | | | | | |
| 13. FATHER'S NAME
Joseph H. Waddell | | | | | 14. MOTHER'S MAIDEN NAME
Ellen Davis | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
UNKNOWN | | | | | 16. SOCIAL SECURITY NO.
UNKNOWN | | | | | 17. INFORMANT
Henderson Funeral Home Abingdon, Virginia | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis.
DUE TO (b) 58 1.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Petty
EXAMINER'S NAME (Type)
Charles S. Petty, M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
5/27/60 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
May 28, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Saltville Cemetery | | 22d. LOCATION (City, town, or country) (State)
Saltville, Virginia | | | | | | | | |
| 23. FUNERAL DIRECTOR
William Cook, Inc.
ADDRESS
1217 St. Paul Street | | | | | 24a. REC'D BY REGISTRAR
JUN 1 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | | | |

UNITED STATES
MARINE CORPS



Baltimore

Baltimore

Spokane Point

Spokane Point

Two Bay Front Road

Two Bay Front Road

John M. F. Davis

John M. F. Davis

Chronic

Handwritten text, possibly a signature or name.

2/27/60

Charles S. Feltz, J.D.

Indivisible, Virginia

Indivisible, Virginia

Indivisible, Virginia

Indivisible, Virginia

5576

CERTIFICATE OF DEATH

05549

Reg. Dist. No. 4...

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland
c. LENGTH OF STAY IN 1b 19 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland
d. STREET ADDRESS 904 East Pratt Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Anna Middle May Last Wallick | | 4. DATE OF DEATH
Month 5 Day 3 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/10/29 |
| 9. AGE (In years last birthday) 30 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Elmer Arthur Wallick | | 14. MOTHER'S MAIDEN NAME Florence Leonna Brenneman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Rosewood Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Status epilepticus com-
353.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) plicated by Lupus erythema-
tosis (c) tosis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:30a M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Peter W. Rieckert | | ADDRESS (Street, city or town, state) 4307 Marlfield Ave | |
| PHYSICIAN'S NAME (Type) Peter W. Rieckert | | DATE SIGNED 5-4-60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 6-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rosewood Cem | | 22d. LOCATION (City, town, or county) (State) Owings Mills Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer Sons | | ADDRESS Rustertown Md | |
| 24a. REC'D BY REGISTRAR MAY 9 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

45.2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5577

CERTIFICATE OF DEATH

Item 2 Film 264 6-7-60 et

05550

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 3 mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Marion Louisa Ward | | 4. DATE OF DEATH May 28 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH October 7, 1876 |
| 9. AGE (In years lost birthday) 83 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Silas Whitelock | | 14. MOTHER'S MAIDEN NAME Lilia Stanford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Edward S. Ward | | Address 7834 St. Bridget Lane 22 MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
420.1 DUE TO ARTERIOSCLEROTIC CU DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO 10 YRS
(c) 2 HRS | | INTERVAL BETWEEN ONSET AND DEATH 2 HRS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TROPHIC ULCERS- FEET | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from FEB. 25 19 60 to MAY 28 19 60 , that (I) (we) last saw the deceased alive on MAY 27 19 60 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John F. Schaefer M.D. | | 22b. DATE SIGNED May 30 - 1960 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. John F. Schaefer | | 22d. ADDRESS 401 Random Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5-31-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens | | 23d. LOCATION (City, town, or county) (State) Belair, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell | | 25a. REC'D BY REGISTRAR DATE JUN 1 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | | | |

R. Madison Mitchell

05500

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0551

Religious

Religious

Religious

Religious

Religious

Religious

Religious

22

05500

Religious

Religious

Religious

05500

ARTERIO-SCLEROTIC - CU. DISEASE 10 YRS
CORONARY OCCLUSION
3 HRS.

05500

05500

05500

05500

05500

05500

05500

05500

05500

05500

05500

05500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5398
CERTIFICATE OF DEATH

05551

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 1b
53 Dundalk | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1630 Searles Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HORATIO Middle NELSON Last WARDROPPER | | 4. DATE OF DEATH
Month May Day 9 Year 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 23, 1901 |
| 9. AGE (In years last birthday)
58 yrs. | | 10. IF UNDER 1 YEAR
Months 5 Days 11 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel | |
| 11. BIRTHPLACE (State or foreign country)
England | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Horatio Wardropper | | 14. MOTHER'S MAIDEN NAME
Isabelle McDonald | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
I | | 16. SOCIAL SECURITY NO.
1 | |
| 17. INFORMANT
Mrs. Jessie Wardropper 1630 Searles Road-22 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
422.1 IMMEDIATE CAUSE (a) A-S-C-V-DISEASE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Accidents - Nov. 10 - 1959 - | | INTERVAL BETWEEN ONSET AND DEATH
10 1/2 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
May 9, 1960 | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1959 to May 9, 1960 , that (I) (we) last saw the deceased alive on May 6, 1960 , and that death occurred at 5 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
M. B. Davis, M.D. | | 22b. DATE SIGNED
5/11/60 | |
| 22c. PHYSICIAN'S NAME (Type)
M.B. Davis, M.D. | | 22d. ADDRESS
6800 Monmouth Ave - Dundalk - Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/12/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City, town, or county) (State)
Colgate, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home Dundalk, Md. | | 25a. REC'D BY REGISTRAR
MAY 13 1960 | |
| 25b. REGISTRAR'S SIGNATURE
Charles S. M... | | 25c. DATE
MAY 13 1960 | |

10030

CERTIFICATE OF DEATH

10030

| | | | |
|------------------------|--|------------------------|--|
| Name of deceased | | Date of birth | |
| Sex | | Race | |
| Marital status | | Place of birth | |
| Cause of death | | Date of death | |
| Place of death | | Signature of physician | |
| Signature of registrar | | Signature of informant | |

10030-1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

| | | | |
|------------------------|--|------------------------|--|
| Name of deceased | | Date of birth | |
| Sex | | Race | |
| Marital status | | Place of birth | |
| Cause of death | | Date of death | |
| Place of death | | Signature of physician | |
| Signature of registrar | | Signature of informant | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5578

CERTIFICATE OF DEATH

05552

Reg. Dist. No.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY none | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural: Towson | | c. LENGTH OF STAY IN 1b
3Y01.4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Eudowood Sanatorium Towson 4, Maryland | | d. STREET ADDRESS
10 E. Hill St. | |
| 3. NAME OF DECEASED (Type or print)
First Leo Middle Washenfelt Last Leo | | 4. DATE OF DEATH
Month May Day 2 Year 1960 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/9/04 |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chaucer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
John Washenfelt | | 14. MOTHER'S MAIDEN NAME
Ellen May | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Personal History | | Address
Hospital Records, Eudowood Sanatorium | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Hemorrhage
DUE TO 002X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
4 hrs
14 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 28, 1946 to May 2, 1960 , that I last saw the deceased alive on May 2, 1960 , and that death occurred at 11:03 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Eudowood Sanatorium, Towson 4, Md. | | | |
| ACTUAL SIGNATURE
Milton B. Kress | | PHYSICIAN'S NAME (Type)
Milton B. Kress, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 6 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 22d. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frank DellaNoce | | ADDRESS
322 S. High St. | |
| 24a. REC'D BY REGISTRAR
MAY 5 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kress | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5579

CERTIFICATE OF DEATH

05553

Reg. Dist. No.

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>5-yr</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Norman P. Waugh</u> | | | | 4. DATE OF DEATH <u>May 1 1960</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept 1-1903</u> | |
| 9. AGE (In years lost birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>W. Va</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>James B Waugh</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma J Duncan</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>234-12-5380</u> | | | |
| 17. INFORMANT <u>Mrs Herman Whittle</u> | | | | Address <u>Upperco Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u>
<u>540.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Peptic ulcer</u> DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>April 30</u> , 19 <u>60</u> , to <u>May 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 30</u> , 19 <u>60</u> , and that death occurred at <u>6 A</u> . M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>W H Ford</u> M.D. <u>Manchester Md</u> <u>5/1/60</u>
PHYSICIAN'S NAME (Type) <u>W H Ford MD</u> <u>Manchester Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>May 4-60</u> | | <u>Pleasant Grove</u> | | <u>Balto MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw S Tipton - Hampstead Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

MEDICAL CERTIFICATION

1955

CERTIFICATE OF DEATH

2525

1

DATE

AGE

DECEASED

DECEASED (NAME) & SEX

DECEASED (ADDRESS)

DECEASED (CITY)

DECEASED (STATE)

DECEASED (ZIP)

DECEASED (DATE OF BIRTH)

DECEASED (DATE OF DEATH)

DECEASED (CAUSE OF DEATH)

DECEASED (MANNER OF DEATH)

DECEASED (SIGNATURE)

DECEASED (WITNESS)

DECEASED (NOTARY)

DECEASED (JURY)

DECEASED (FAMILY)

DECEASED (FRIENDS)

DECEASED (CLOSING)

DECEASED (FINAL)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05554

Reg. Dist. No.

5580

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Graceland Park | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Graceland Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6910 Norman Ave. | | | | d. STREET ADDRESS
6910 Norman Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First STEPHEN Middle WDZIECZNY Last WDZIECZNY | | | | 4. DATE OF DEATH
Month May Day 18 Year 1960 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 14, 1890 | 9. AGE (In years last birthday)
69 yrs. | IF UNDER 1 YEAR
Months 69 Days 18 Hours 18 Min. | IF UNDER 24 HRS.
Months 69 Days 18 Hours 18 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Grocer. | | 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Wdzieczny | | | | 14. MOTHER'S MAIDEN NAME
Jane ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
213-28-6792 | | 17. INFORMANT
Mary Wdzieczny | | Address
Same. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Acc
DUE TO 331X
Conditions, if any, which gave rise to immediate cause (b) Hyper Extension
(c) Due to
DUE TO 331X
(a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
17 hrs.
10 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Jack C Collins M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Jack C Collins | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-21-60. | | 22c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Mary Cem. | | 22d. LOCATION (City, town, or county) (State)
German Hill Rd., Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles S. Gierler | | | | 24a. REC'D BY REGISTRAR
DATE MAY 23 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

MEDICAL CERTIFICATION

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 5399 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 05555 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7307 Shipway | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk
d. STREET ADDRESS 7307 Shipway
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
LAURA Catherine WEATHERLY | | | | | | 4. DATE OF DEATH
Month Day Year
May 31 1960 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 31, 1959 | | 9. AGE (In years last birthday) yrs. 5 | | IF UNDER 1 YEAR
Months Days
5 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
DeWitt Lee Weatherly | | | | | | 14. MOTHER'S MAIDEN NAME
Mary B. Moon | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
D.L. Weatherly | | | Address
Same as #2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemoperitoneum
902.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Ruptured Liver
(e), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Slipped from father's grasp | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
9:30 5/30 1960 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Dundalk Baltimore Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles S. Petty
EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5/31/60 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
6/1/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | | 22d. LOCATION (City, town, or country) (State)
Baltimore Co., Maryland | | |
| 23. FUNERAL DIRECTOR
Walter Brooks Bradley, Inc. | | | | | | 24a. REC'D BY REGISTRAR
JUN 2 '60
24b. REGISTRAR'S SIGNATURE
Arthur L. Klaus | | | | | |

2038201XV5



203850x12

Editor: Thomas M. Brown, Inc., 1000 15th St., N.W., Washington, D.C. 20005
Date: May 1, 1965

Dear Mr. Brown:

I am writing to you regarding the matter of the

contract for the purchase of the

property located at 1000 15th St., N.W.

Washington, D.C. 20005.

The property is located in the

area of the city of Washington, D.C.

and is situated on the corner of 15th St.

and M St., N.W.

The property is currently owned by

the United States Government.

I am writing to you regarding the

matter of the purchase of the property.

5581

CERTIFICATE OF DEATH

Reg. Dist. No. 05556

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn 7</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4105 Essex Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Irene L. Weber</u> | | 4. DATE OF DEATH <u>May 8 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/22/88</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Neumann</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Senner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Burnett Ziegler</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the breast - metastatic</u>
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular disease</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 5, 1958</u> , to <u>May 8, 1960</u> , that I last saw the deceased alive on <u>May 7, 1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Helen Gundersheimer Jr.</u> M.D. <u>Riverside Gts Lake Drive</u> | | DATE SIGNED <u>5/8/60</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/11/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Macraft & Son</u> ADDRESS <u>28</u> | | 24a. REC'D BY REGISTRAR <u>MAY 11 1960</u> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur D. Harris</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5582

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perry Hall</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perry Hall</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9221 Carlisle Avenue</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Emma</i> First Middle Last <i>Wehrle</i> | | 4. DATE OF DEATH Month <i>May</i> Day <i>27th</i> Year <i>1960</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 20, 1876</i> |
| 9. AGE (In years last birthday) <i>83</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Heinrich Leonhardt</i> | | 14. MOTHER'S MAIDEN NAME <i>Ernestina Adolph</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <i>Mr. Frederick A. Wehrle</i> Address <i>same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, generalized severe</i>
DUE TO
(c) <i>Diabetes, malaise</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>March 22</i> , 19 <i>60</i> , to <i>May 27</i> , 19 <i>60</i> that I last saw the deceased alive on <i>May 24</i> , 19 <i>60</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Theodore E. Evans</i> | | ADDRESS (Street, city or town, state) <i>9660 Belair Road</i> DATE SIGNED <i>May 27, 1960</i> | |
| PHYSICIAN'S NAME (Type) <i>Theodore E. Evans</i> | | <i>Baltimore 6, Maryland</i> | |
| 22a. BURIAL, CREMATION, or other disposition <i>burial</i> | 22b. DATE THEREOF <i>5/30/60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i> | | 24a. REC'D BY REGISTRAR <i>MAY 31 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

385

5583

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Balto. | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | | c. LENGTH OF STAY IN 1b | | X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
College Manor Nursing Home | | | | d. STREET ADDRESS
18201 Loch Raven Blvd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
Dorothy | | First Dorothy Middle Weidig Last Weidig | | 4. DATE OF DEATH
Month 5 Day 12 Year 1960 | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 20, 1880 | | |
| 9. AGE (In years lost birthday)
79 yrs. | | IF UNDER 1 YEAR
Months 7 Days 22 | | IF UNDER 24 HRS.
Hours 22 Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
New York City | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
William H. Hevert | | | | 14. MOTHER'S MAIDEN NAME
Wilhemina Krebs | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
082-01-6628D | | INFORMANT Address
Mrs. W.E. Grady, 2 Park Circ. Towson 4MD | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 332X Central thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Central arteriosclerosis
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
days
yr - | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from May 3 , 19 58 to May 12 , 19 60 , that I last saw the deceased alive on May 11 , 19 60 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE Ernest C. Brown Jr. | | M.D. 1101 N. Calvert St | | ADDRESS (Street, city or town, state) | | DATE SIGNED 5/12/60 | | |
| PHYSICIAN'S NAME (Type) Dr. Ernest C. Brown, Jr. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal/Burial May 14, 1960 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
Evergreen Cemetery | | 22d. LOCATION (City, town, or county) (State)
Brooklyn, New York | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John Burns' Sons, Towson, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE MAY 16 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | |

1983

CERTIFICATE OF DEATH

THE VITALS

IN THE

STATE OF

OFFICE OF THE

DATE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF BIRTH

1983

RECEIVED

NEW YORK

1983

NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05559

5584

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Millers</u> | | | | c. LENGTH OF STAY IN 1b
<u>3601.4</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS
<u>1105 Weldon Ave.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>James</u> Last <u>Wells</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>22</u> Year <u>19 60</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug. 2, 1923</u> | |
| 9. AGE (In years last birthday)
<u>36</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Civil Engineer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U. S. Gov't.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u> </u> | | | | | | | |
| 13. FATHER'S NAME
<u>Elmer Wells</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Edith D. Wood</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT Address
<u>Mrs. Edith Wood - 1105 Weldon Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div> <div> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u>
 <u>973.3</u> DUE TO
 Conditions, if any, which gave rise to immediate cause (b) <u> </u>
 (a), stating the underlying cause lost. (c) <u> </u> DUE TO <u> </u> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>5/23/60</u> | | | |
| EXAMINER'S NAME (Type) <u>A. M. France</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/26/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Pikesville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. J. Lickner & Sons - Balt</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 24 60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. France</u> | |

TO DETERMINE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5585

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) REISTERSTOWN | | c. LENGTH OF STAY IN 1b 3 mos. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First AMY Middle CROCKETT Last WHITE | | 4. DATE OF DEATH
Month MAY Day 13 Year 1960 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 27, 1898 |
| 9. AGE (In years lost birthday) 62 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) TANGIER ISLAND VA U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME LOUIS CROCKETT | | 14. MOTHER'S MAIDEN NAME JENNY CONNOR | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Address | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.
(b) Kidney and cardiac decompensation DUE TO
(c) Arteriosclerotic C.V.Disease DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
4-5 days
6 months
1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from December , 19 59 , to May 13 , 19 60 , that I last saw the deceased alive on May 13 , 19 60 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Martin E. Strobel | | ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 5-13-60 | |
| PHYSICIAN'S NAME (Type) Martin E. Strobel M.D. | | Reisterstown, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5-17-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY PARKWOOD | | 22d. LOCATION (City, town, or county) (State) BALTO. MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Hayfield | | 24a. REC'D BY REGISTRAR DATE MAY 18 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5400

CERTIFICATE OF DEATH

05561

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | | c. LENGTH OF STAY IN 1b <u>53 Dundalk Rd</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 Fairbanks Ct</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>White</u> Last <u>White</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 2-1906</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Issac Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Johnson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT <u>Nathaniel Johnson</u> | | Address <u>102 Cherry Lane W.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u>
420-1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u>
DUE TO (c) <u>8 yrs</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5-10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>JUN 1948</u> , 1948, to <u>MAY 24</u> , 1960, that I last saw the deceased alive on <u>MAY 24</u> , 1960, and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William C. Wade</u> | | M.D. <u>140 Oak Ave.</u> DATE SIGNED <u>5-24-60</u> | |
| PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u> | | <u>Dundalk 1122, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5-27-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Law</u> | | ADDRESS <u>802 Madison Ave.</u> | 24a. REC'D BY REGISTRAR <u>MAY 26 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------------------------|--|----------------------------------------------------------|--|-----------------------------------------------------------------|--|
| <p>NAME OF DECEASED
 <i>William A. M. M. M.</i></p> | | <p>AGE
 <i>25</i></p> | | <p>SEX
 <i>Male</i></p> | |
| <p>DATE OF DEATH
 <i>Jan 10 1910</i></p> | | <p>TIME OF DEATH
 <i>10:00 AM</i></p> | | <p>PLACE OF DEATH
 <i>Home</i></p> | |
| <p>CAUSE OF DEATH
 <i>Heart Disease</i></p> | | <p>IMMEDIATE CAUSE
 <i>Myocardial Infarction</i></p> | | <p>PREVAILING DISEASE
 <i>Coronary Artery Disease</i></p> | |
| <p>DATE OF BIRTH
 <i>Jan 10 1885</i></p> | | <p>PLACE OF BIRTH
 <i>Baltimore, Md.</i></p> | | <p>EDUCATION
 <i>High School</i></p> | |
| <p>OCCUPATION
 <i>Teacher</i></p> | | <p>RELIGION
 <i>Methodist</i></p> | | <p>MARRIAGE
 <i>Married</i></p> | |
| <p>NAME OF PHYSICIAN
 <i>Dr. J. H. Smith</i></p> | | <p>NAME OF FUNERAL HOME
 <i>None</i></p> | | <p>NAME OF BURIAL PLACE
 <i>Greenwood Cemetery</i></p> | |
| <p>SIGNATURE OF PHYSICIAN
 <i>J. H. Smith</i></p> | | <p>SIGNATURE OF FUNERAL HOME
 <i>None</i></p> | | <p>SIGNATURE OF BURIAL PLACE
 <i>Greenwood Cemetery</i></p> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5586

CERTIFICATE OF DEATH

05562

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>md.</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i> | | c. LENGTH OF STAY IN 1b <i>3701.4</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manor -</i> | | d. STREET ADDRESS <i>600 W. Cold Spring Lane</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>IDA T. VERNON-Williams</i> | | 4. DATE OF DEATH Month Day Year <i>May 29 1960</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>June 5, 1878</i> |
| 9. AGE (In years lost birthday) <i>81</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. <i>81</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Wm. T. Miller</i> | | 14. MOTHER'S MAIDEN NAME <i>Emma V. Thomas</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Mr. F.R. Vernon-Williams</i> | | Address <i>600 W. Cold Spring Lane</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Cancer of liver</i>
DUE TO <i>156.1</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i>
DUE TO (c) <i>—</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>May 28, 1960</i> to <i>May 29, 1960</i> , that (I) (we) last saw the deceased alive on <i>May 28, 1960</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>CRAWFORD N. KIRKPATRICK, JR</i> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Crawford N. Kirkpatrick, Jr.</i> | | 22d. ADDRESS <i>6 E. Eager St. Baltimore 2, Md.</i> | |
| 22b. DATE SIGNED | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 2, 1960</i> | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons Co. 4905 York Rd.</i> | | 25a. REC'D BY REGISTRAR <i>JUN 2 '60</i> | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i> | |

CERTIFICATE OF DEATH

1888

John Doe

John Doe, of the County of ... State of ...
born at ... on the ... day of ... 18...

He was ... years of age at the time of his death.
He was ... of the ...

He died at his late residence on the ... day of ... 1888.
The cause of death was ...

He was buried at the ... on the ... day of ... 1888.
The funeral services were held at the ...

Witness my hand and the seal of the ...
at the City of ... on the ... day of ... 1888.

Signature of the Registrar
Official Seal

Signature of the Physician
Official Seal

Signature of the Minister of the Gospel
Official Seal

Signature of the Coroner
Official Seal

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5587

CERTIFICATE OF DEATH

05563

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE | | c. LENGTH OF STAY IN 1b 4 MONTHS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | | d. STREET ADDRESS 106 WEST UNIVERSITY | |
| 3. NAME OF DECEASED (Type or print) SAMUEL J WILLIAMSON First Middle Last | | 4. DATE OF DEATH MAY 8 1960 Month Day Year | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-4-1881 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U-S | |
| 13. FATHER'S NAME JAMES O. WILLIAMSON | | 14. MOTHER'S MAIDEN NAME MARGARET Williamson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 110-10-4482 | |
| 17. INFORMANT Frank L. Smith Jr. - Cockeysville, MD Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio
422.1 DUE TO Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-16 , 19 60 , to 5-8 , 19 60 , that (I) (we) last saw the deceased alive on 5-6 , 19 60 , and that death occurred at 6:25 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Walter T. Kees | | 22b. DATE SIGNED 5/8/60 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER T. KEES | | 22d. ADDRESS COCKEYSVILLE, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 5-11-60 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION (City, town, or county) (State) Baltimore |
| 24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | 25a. REC'D BY REGISTRAR MAY 10 1960 25b. REGISTRAR'S SIGNATURE Charles E. Kraus | |

OP

100-100

CERTIFICATE OF DEATH

1885

BRITISH

CHURCH

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

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100-100

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100-100

100-100

100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05564

5588

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson | c. LENGTH OF STAY IN 1b
15 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 23 | 3 Vol. 4 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | d. STREET ADDRESS
2014 Boyd Street | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle WILLARD Last WOOD | | 4. DATE OF DEATH
Month May Day 2 Year 1960 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 20, 1890 |
| 9. AGE (In years last birthday)
68 1/2 yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Truck driver | | 10b. KIND OF BUSINESS OR INDUSTRY
Lumber Co. | 11. BIRTHPLACE (State or foreign country)
Rock Hill, S.C. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
William C. Wood | |
| 14. MOTHER'S MAIDEN NAME
Minnie E. Crook | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
Unknown | |
| 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinoma of stomach with widespread metastasis
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Far advanced bilateral cavity pulmonary tuberculosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
002X | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from April 18, 1960 , to May 2, 1960 , that I last saw the deceased alive on May 2, 1960 , and that death occurred at 10:59 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____ | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
May 5, 1960 | 22c. NAME OF CEMETERY OR CREMATORY
Edgar Hill Cem. | 22d. LOCATION (City, town, or county) _____ (State) _____
Balto. Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. Truman Schwal | | 24a. REC'D BY REGISTRAR
DATE MAY 5 '60 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Harris |

3512 Frederick Ave. (29)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

05565

Item 14 FilmG264 6-3-60 et

| | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|---------------------------------|--|---------------------------------------------------------------------------------------------------|--|------------------|--|
| 1. PLACE OF DEATH
a. COUNTY | | Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE | | Maryland | | b. COUNTY | | Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Sparrows Point | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Sparrows Point | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 707 E Street | | d. STREET ADDRESS | | 707 E Street | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) | | First | | Middle | | Last | | 4. DATE OF DEATH | | Month | | Day Year | |
| ELIZABETH | | H. | | WRIGHT | | | | May | | 21 | | 19 60 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | December 7, 1875 | | 84 yrs. | | Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| At home | | | | Maryland | | U.S.A. | | | | | | | |
| 13. FATHER'S NAME | | Benjamin Buckmaster | | 14. MOTHER'S MAIDEN NAME | | Sophia Brightwell | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | |
| No. | | | | Robert C. Wright | | 707 E Street-19 | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH | | 3 days | | | | | |
| 420.0 | | DUE TO | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Arteriosclerotic Heart Disease | | 15 years | | | | | | | |
| DUE TO | | (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| Hour a. m. p. m. | | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1960, to May 21, 1960, that (I) (we) last saw the deceased alive on May 12, 1960, and that death occurred at 7 AM, from the causes and on the date stated above. | | 22a. SIGNATURE | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | RG WINDSOR | | 22d. ADDRESS | | 520 D St. Sp R 15, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | (State) | | | | | |
| Burial | | 5/23/60 | | Parkwood Cemetery | | Parkville, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Ullrich Funeral Home Dundalk, Md. | | | | DATE MAY 25 '60 | | Arthur S. Thomas | | | | | | | |

05505

05505

Bellevue

Bellevue

Bellevue



Bellevue

Bellevue

Bellevue

Bellevue

Bellevue



Bellevue

Bellevue



Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05566

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | c. LENGTH OF STAY IN 1b
24 hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Finksburg 06x-2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
10834 Reisterstown Road | | | | d. STREET ADDRESS
Gamber Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Robert Eugene Zentz | | | | 4. DATE OF DEATH
Month May Day 25 Year 1960 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 19, 1917 | | 9. AGE (In years last birthday)
42 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Roofer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Earl W. Zentz | | | | 14. MOTHER'S MAIDEN NAME
Ethel Pittinger | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
219-05-0549 | | 17. INFORMANT
Mr. John Zentz | | Address
Finksburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
1 1/2 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. none 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) (County) (State)
none | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5-25-60 | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 27, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Finksburg Cemetery | | 22d. LOCATION (City, town, or county) (State)
Finksburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. F. Eline & Sons Reisterstown, Md. | | | | 24a. REC'D BY REGISTRAR
DATE MAY 27 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hines | |

